

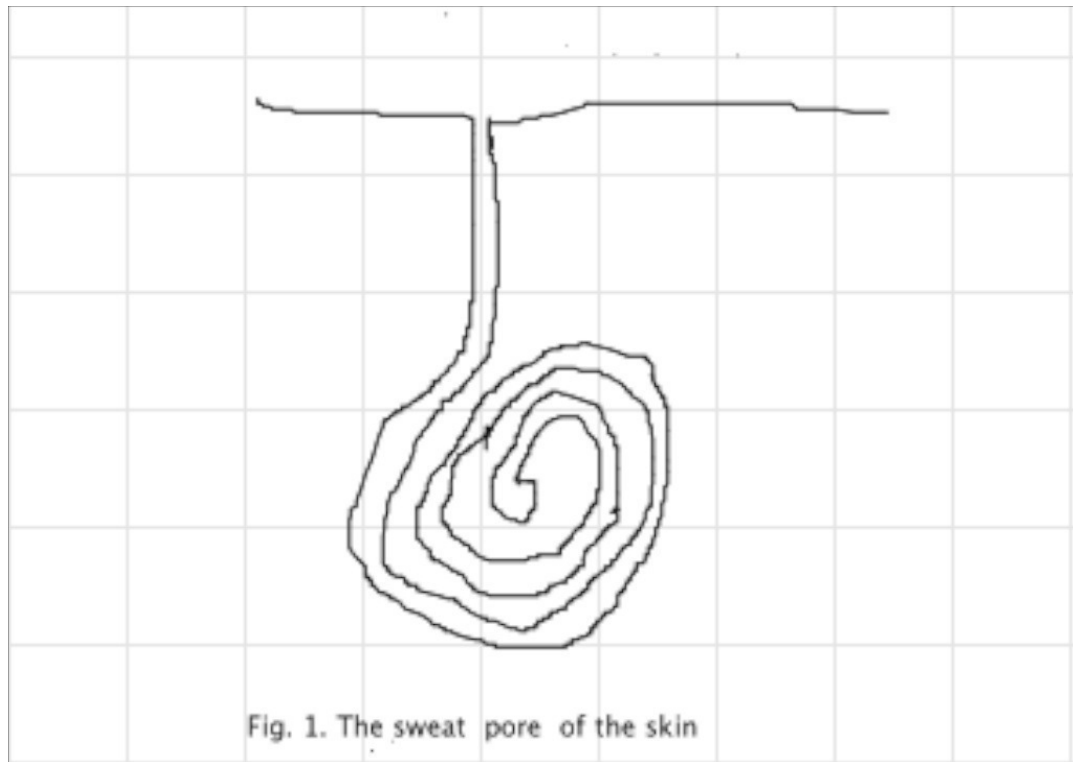
Explain What Can Be Done To Help Protect The Skin of Patients ?

An explanation of the interventions, that may be implemented to help protect the skin of a patient, will take many factors into consideration. Most of these factors are based on current and previous research.

An understanding of the anatomy and physiology of the integumentary system is a useful starting place.

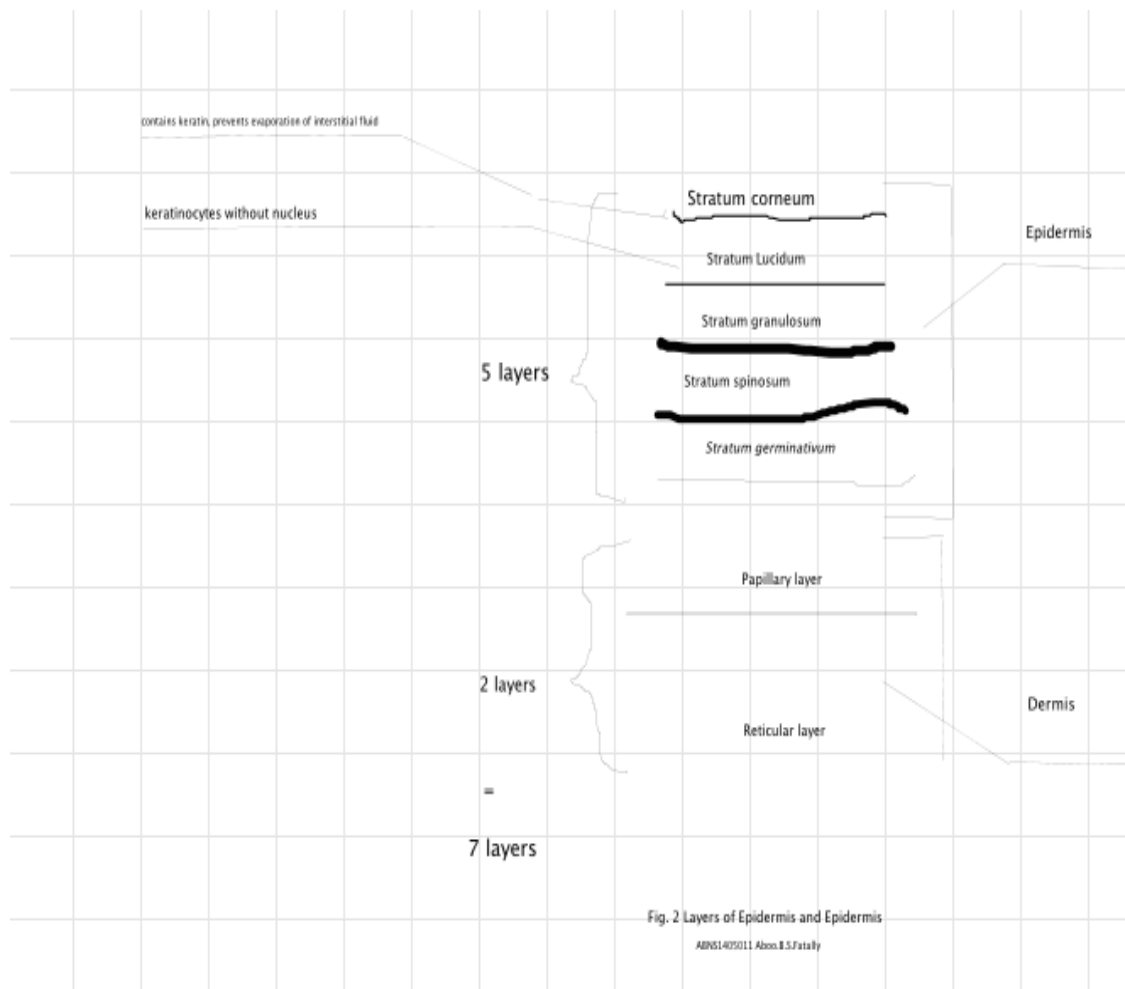
Human skin integumentary system has taken million of years to develop. It is about 2 square meters in size and weighs about 4.5 kg. It has a network of arterioles, veins, nerves, cells, proteins and chemicals, that function together to protect the body against injuries and infiltration of organism seeking colonisation.

The skin has its own defensive mechanism in place. The intervention to protect, first, would enhance this built in mechanism. This can be done as follows:

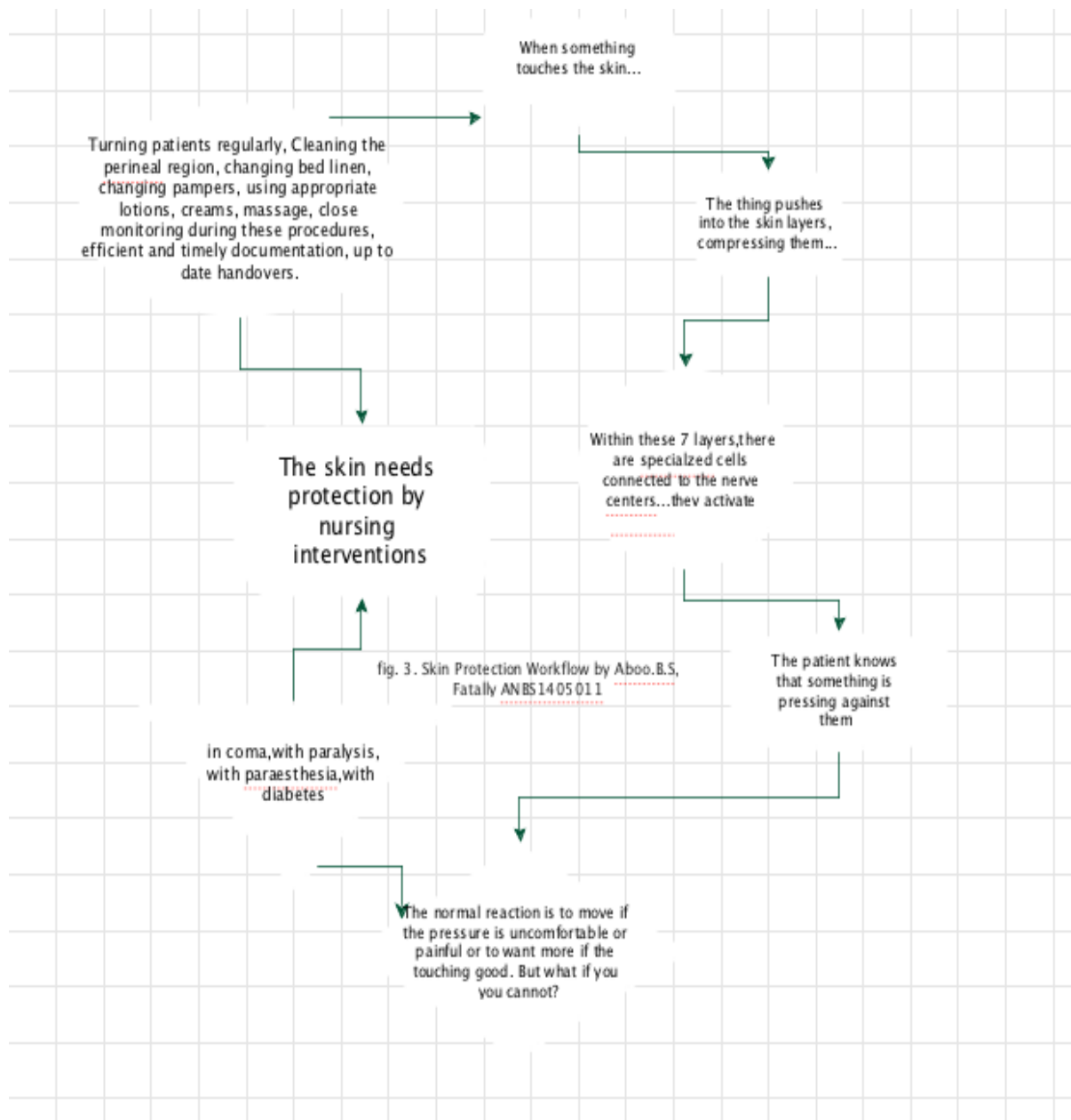


The skin has pores that allow sweat to flow from the interstitial, extracellular, intracellular fluid, plasma and blood stream to the surface. The fluids evaporate, in the process, heat is reduced. The heat may be caused by increased metabolism, invasion by organism. So the use of perfume powder will block the openings of the sweat pores preventing reduction and whatever perspiration has taken place, the moisture will be mixed with the powder to produce a paste. This would provide the sort of environment where harmful, opportunistic bacteria will thrive and begin colonisation.

The skin has an epidermal layer that is built up with a set of five sublayers sitting on top of the papillary layer of the dermis, the layer underneath the epidermis * Each has specific functions. The first layer is the corneum stratum. It is a layer of dead cells without nucleus it contains keratin, a protein that keeps the skin hydrated by preventing water evaporation. Much heat is lost by convection. To help heat loss the skin is covered with appropriate clothing as may be required, bed linen, space blanket. Further the temperature of the environment may be adjusted to normal room temperature by Air-conditioning.



The skin can withhold variable pressure. There are cells* in the skin that are sensitive to degrees of pressure. They are connected to the central nervous system by neurones. Fillipo Pacini, an Italian, discovered the pacinian corpuscle, a lamellar structure at the tip of a neurone, when the lamellae curves by touch, it releases Na^+ which trigger an action potential along the nerve propagating towards the node of Ranvier, then central processing by the central nervous system. Any interference with the normal signal processing of these corpuscles, including the Merkel corpuscles and the Meissner corpuscles will cause the patient to be unaware of the sensation. In medical conditions such as paralysis, coma, stroke, diabetes with make the skin liable to fail in its functions.



The skin Langerhan cells produces peptides that are antimicrobial. As long as the skin receives a good supply of nutrients, it will produce enough antibacterial peptides to provide protection. It is common sense to believe that any medication that is not compatible with those peptides will result in a diminished defence. The skin has very violent reactions to medications and objects that, it does not agree with. Patients do have allergies and very bad reactions, even deadly. Care must be taken on admission to ascertain that the patient history of allergies are well documented.

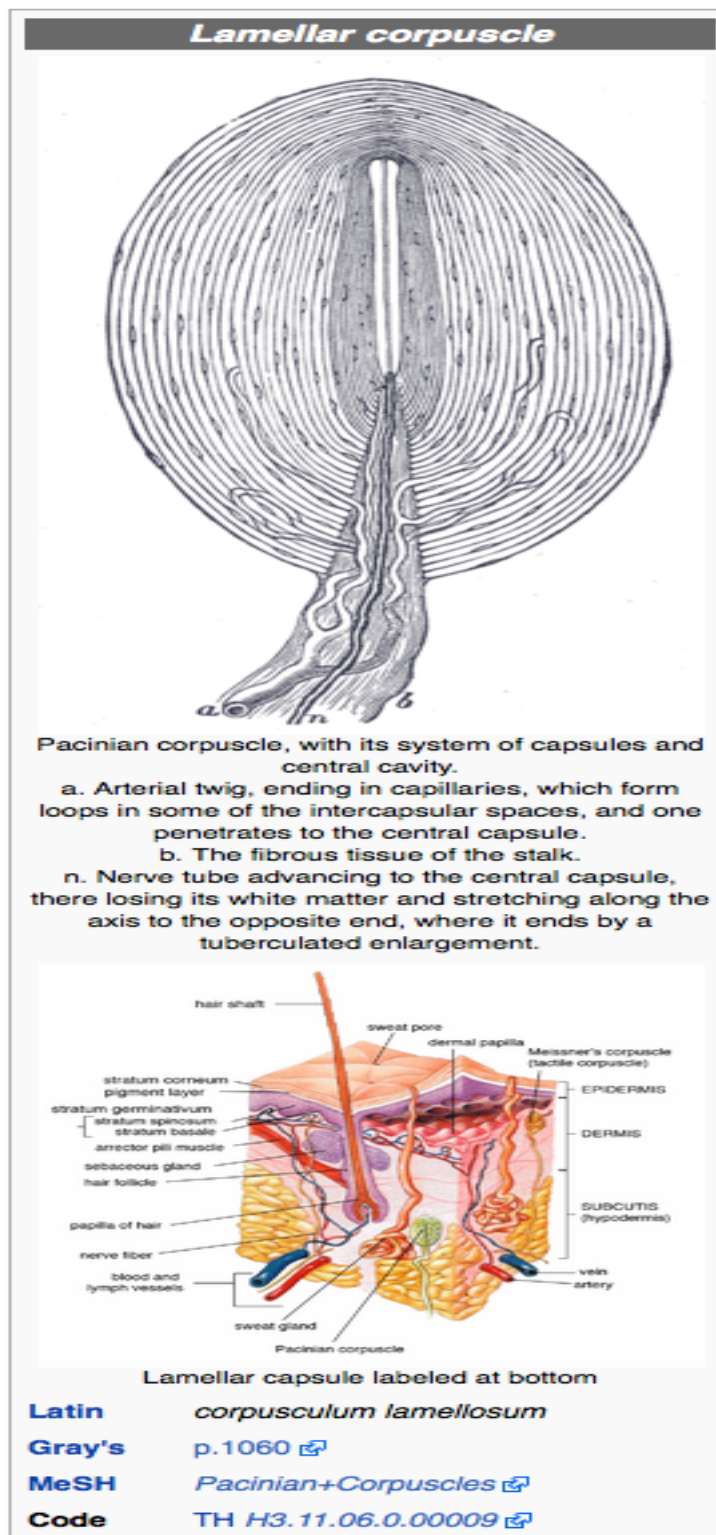
The skin of patient is protected by the use of technique of washing which involves using one swipe with one gauze in one direction then discarding it in one bag. In this way any exudate is removed without spreading in other areas, cleaning from the clean towards the unclean areas. Rubbing to and fro is strongly disapproved.

Patient in coma requires turning over and over regularly. It is known that decubitus ulcers is the direct results of the lack of nursing interventions. The patient would require back massage such as "Petrissage, Effleurage, Eclairage, Massage".

A nurse never trims the nails of a diabetic patient. Patient are given bed baths to prevent infecting agent getting under the skin. The hair is shampooed to remove dusts, dead skins.

Always the lips of patient because if it is pale, there is a possible low erythrocytes count. The nails indicates oxygenation of the haemoglobin.

Appendix 1



Bibliography, References and Citations.

The education system in Mauritius, patterned after the British model, has improved greatly since independence. It has been free through the secondary level since 1976 and through the postsecondary level since 1988. The government has made an effort to provide adequate funding for education, occasionally straining tight budgets. In 1991-92, reflecting the trend of earlier budgets, the government allocated 13 percent (Mauritian rupee--MauR--see Glossary --1.5 billion) for education, culture and art. Nonetheless, facilities in rural areas tend to be less adequate than those in Port Louis and other cities. Literacy in 1990 for the population over fifteen years of age on the island of Mauritius was 80 percent overall, 85 percent for males, and 75 percent for females.

In 1979 the government established a new unit in the Ministry of Education and Cultural Affairs to oversee and coordinate teaching resources at some 900 private preschools. The increasing participation of women in the labor force necessitated the expansion of the preschool system. The government established public preschools in 1984. Primary education (standard 1-6) is compulsory, and 6,507 teachers taught 137,491 students in 283 schools in 1990, representing an estimated 92 percent of children in that age group. During the same period at the secondary level (forms 1-6), 3,728 teachers taught 78,110 students in 124 schools. As in the British system, students must pass standardized exams at several stages to be able to continue their studies. About 50 to 60 percent of primary students pass the exam for admission to secondary school. In 1986, 60.7 percent of the form 5 students taking the School Certificate exam passed; not all went on to form 6. In the same year, 53.7 percent of the form 6 students taking the Higher School Certificate exam passed. In addition to government schools, there are many private primary and secondary schools, but statistical data on these are lacking.

The country's principal institution of higher education is the University of Mauritius, where 1,190 students were enrolled in 1991. Other postsecondary institutions include the Mauritius Institute of Education for teacher training; the Mauritius College of the Air, which broadcasts classes; and the Mahatma Gandhi Institute. Of the several hundred Mauritians studying abroad each year, most go to Britain, France, and India. In addition, 1,190 students were enrolled at eleven vocational training centers, and 690 were taking courses at three technical institutions and five handicraft training centers in 1991.

From standard 4 onward, English is the sole language of instruction. Before that, teachers use Creole and Bhojpuri when teaching English to those students who do not already know it. From standard 3 onward, French is a required course. Students may also take classes in several Asian languages.

The government of Mauritius regards education as a sphere of utmost importance in its move toward the "second stage" of economic development, namely becoming a newly industrialized country. Therefore, at a donors' meeting in Paris in November 1991, the minister of education presented an ambitious Education Master Plan for the years 1991-2000. The plan calls for expanding education at all levels, from preprimary through university, through the establishment of new schools and the improvement of existing facilities, especially technical and vocational education; the latter is an area that to date had not provided the technical skills required by island industries. Despite the population's 95 percent literacy rate for those under thirty years of age, government officials have been concerned at the high dropout rate, especially at the secondary level. University places are also being increased to 5,000, and new courses of study are being introduced. The donor response to the plan was very favorable. The World Bank pledged US\$20 million, the African Development Bank US\$15 million, and other donors an additional US\$14 million.

Read more at <http://www.mongabay.com/history/mauritius/mauritius-education.html#YdKGczdC4HJvAd2Z.99>



Participants can choose any **one** topic from the list given below.

- (1) The present system of Education in Mauritius.
- (2) Ageing and its impact on the Mauritian society.
- (3) Crime and Punishment in Mauritius.
- (4) Diabetes and the consequences for the Mauritian population.
- (5) Discuss the advantages and disadvantages of an expanding tourist industry in Mauritius.
- (6) What contributions can we make as individuals to help protect the environment?

Individual Assignment

Each student has to submit a type copy of his/her work. The essay should be of 500 – 600 words. This assignment carries 15 Marks. The allocations of marks are as follows:

- | | |
|---|---------|
| 1. Presentation of work..... | 3 Marks |
| 2. Appropriate use of English Language, grammar, vocabulary, punctuation, syntax..... | 3 Marks |
| 3. Relevance of ideas..... | 3 Marks |
| 4. Coherence of ideas..... | 2 Marks |
| 5. Use of up to date research to back up arguments and Discussion..... | 4 Marks |

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Here is a brief overview of educational system in Mauritius.

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The education system in Mauritius is largely based on the [British system](#) since Mauritius was a former British colony. After the country became independent in 1968, education became one of the main preoccupations of the Mauritian Government to meet the new challenges awaiting the country.

[Primary Education](#)

The Primary Curriculum Framework has been developed within the broader perspective of the National Curriculum Framework for the Republic of Mauritius along the lines laid down in the document issued in September 2006 by the [Ministry of Education](#) & Human Resources entitled “Towards a Quality Curriculum – Strategy for Reform”.

Banking and Finance in Mauritius
How To Register Business in Mauritius
Industrial Policy of Mauritius
Natural Resources in Mauritius
Services Sector in Mauritius
Tax Structure in Mauritius

Mauritius Economy

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- ✦ [FinnTec 2014](#), Helsinki
06-05-2014 ~ 08-05-2014
- ✦ [Lab Indonesia 2014](#), Jakarta
07-05-2014 ~ 09-05-2014
- ✦ [Interpack 2014](#), Dusseldorf
08-05-2014 ~ 14-05-2014
- ✦ [BEFA 2014](#), Dusseldorf
29-05-2014 ~ 31-05-2014
- ✦ [Metef 2014](#), Verona
11-06-2014 ~ 14-06-2014

The Primary Curriculum Framework provides teachers, parents and the community at large with a clear statement of what pupils are expected to achieve at the end of their primary schooling and how they can best support the children. It also makes it possible for curriculum developers and teachers to develop [learning and teaching](#) programmes which meet the needs of the pupils while at the same time responding to the needs of the country. The Primary Curriculum Framework will help teachers:

- To better understand the process of the national educational endeavor
- To devise and adopt programmes and strategies to meet the specific needs of their pupils
- To measure the effectiveness of their teaching against the outcomes outlined in the document
- To take appropriate remedial measures whenever this is deemed necessary.

Secondary Education in Mauritius:

Various private as well as government institutions offer secondary education in Mauritius. After completing the primary education, students are automatically admitted to the secondary level of education, with the latter continuing for the next five years. The successful completion of the Cambridge School Certificate Examinations marks the end of secondary education in Mauritius.

[Tertiary Education](#)

The Mauritian Tertiary Education Sector has witnessed major expansion and diversification in recent years. From a small-scale provision by the College of Agriculture (set up in 1924), an expanded and diversified system has evolved with the constituent institutions being public, private, regional and overseas.

Within the public sector, there exist two universities, namely the University of Mauritius and the University of Technology, Mauritius, which run both undergraduate and postgraduate programmes including at the level of PhD in a range of disciplines.

Three Polytechnics, managed by the Technical School Management Trust Fund, also run programmes at the certificate and diploma levels within the public sector. These are the Sir Guy Forget Lycée Polytechnique, the Swami Dayanand Institute of Management, and the "Institut Supérieur de Technologie".

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1. The education system at the end of the twentieth century: an overview

1.1 Major reforms and innovations introduced in the education system during the last ten years

(a) Legal Framework

Education at all levels is governed by the Education Act of 1996. Regulations related to the pre-primary sector have been effective as from May 1997.

Under regulation 37, Subsection (1), and (2) of the Education act of 1993, all children must attend primary school, failing which the responsible party is liable to a fine and imprisonment. Admission to a Government or aided primary school is granted to pupils at the age of 5 until they are less than 13.

(b) already given in report done in 1995

(c) Evaluation policies, methods and instruments

Evaluation policies are regulated by

- (i) a national examining body - the Mauritius Examinations Syndicate which conducts all validated examinations including the Certificate of Primary Education (CPE), the Cambridge School Certificate (SC) and the Higher School Certificate (HSC), Technical and Vocational examinations, professional examinations for more than 50 examinations bodies, and other locally organised examinations.
- (ii) internal examinations carried out at the end of the academic year for all other grades (primary and secondary)
- (iii) a term report at the end of every term informing parents of the performance of their children and drawing attention to the weaknesses
- (iv) tests (written and oral) are carried out in the classroom by individual teachers to monitor the progress of the students.

The main method is a written examination, oral tests, projects are other means which teachers have recourse to at times.

Primary inspectors ensure that work set is properly corrected and that units of knowledge taught are consolidated.

In the secondary sector, heads of department see to it that teachers give a minimum of written work which must be corrected.

(d) Objectives and principal characteristics of current and forthcoming reforms

Reforms at the preschool, primary and secondary levels will address the following issues:

- The abolition of ranking at the CPE and fierce competition at an early age with the concomitant introduction of a new framework of Education of Excellence for all;
- The introduction of a 9-year compulsory and fundamental education cycle;
- The adoption of the principle of regionalisation of secondary intake with provision of schools of equal standards in each region;
- The elimination of streaming in schools;
- The bringing of Science and Technology at the forefront of our Education system;
- The employment of the child to become equipped with qualities important for society and the world of work.

In effect, the new system puts the interest of the child and the nation first, providing him/her to live in a plural society and eventually in a global world.

1.2 Major achievements, both quantitative and qualitative, attained over the last ten years.

1. Preprimary Education

In order to make preprimary education accessible to every child, specific measures have been taken along various lines. Children in the age group 4 to 5 receive a per capita grant. Additional Preprimary classes have been added to existing and new primary schools while the private sector is encouraged to set up its efforts to provide quality pre-primary education. Standards and guidelines have been developed to ensure that the physical environment of the school is pleasant to allow the child to develop fully, both physically, emotionally and mentally. Today 177 out of 278 primary schools have a preschool centre while 1,000 private preschools are registered with the Ministry.

Emphasis is placed on the right kind of training of preschool educators in programmes that, along with the necessary pedagogical skills, give them better insight into the psychology of children. The current Teacher's Certificate Course run by the MIE has been made accessible to all suitably qualified preschool teacher candidates and a proficiency course is being run for period of 2 years through Distance Education mode for those who do not yet qualify for TCC such that by 2003 (year) no under qualified teachers will be allowed to teach in this sub-sector.

The curriculum, centred around real-life experiences and exercises for children, has been designed/improved to help develop personal and social skills and contribute to their readiness for subsequent school-based learning.

Children's experiences at home contribute significantly to achievement. Parents and teachers are encouraged to work together to support children's learning: parents' involvement strengthens children's progress and confidence. To this end, the Ministry of Education, Science and Technology cooperates with the Ministry of Health, Ministry for Women's Rights, Family Welfare and Child Development and with international and local non-governmental organisations to develop holistic, integrated and participatory preschool programs and facilities.

2. Primary Education

The infrastructure of about 25 schools has been improved with repairs, renovations and extensions. 12 new buildings have been put up.

The basic goal at this level is to ensure that all pupils attending primary schools will be able to acquire basic competencies while recognising, allowing and accommodating for diversity in their abilities, aptitudes and interests. To this end, the curriculum takes into account the balance between the knowledge and skills that can be imparted and the aptitudes of pupils at particular grades.

A Guideline for a National Curriculum Basic Education has been developed in terms of Objectives, Methods, Achievement levels and Evaluation according to grade level and subjects. This will not, however, deflect from present efforts to promote a degree of decentralisation of the curriculum, to allow for school specificities, based on inputs from teachers in the preparation of materials, monitoring of the effectiveness of newly introduced textbooks and continuous assessment of achievement levels of students.

Different learning capabilities demand the introduction of remediation strategies, but remediation can only take place after early detection of learning difficulties which may however differ among pupils in intensity. Various strategies/types of intervention are being developed to ensure that children acquire the basic knowledge and lifeskills to enter the world as active, independent and self-sufficient participants in society. Students who fall behind are streamed into remediation activities will be upgraded to catch up with the average ability group to continue to secondary schools. As for children with special needs, the services of psychologists are tapped while the curriculum will allow greater flexibility in practice and teaching methods for them.

Specific remedial components have been included in pre-service and school-based in-service training programs of teachers to make capable of providing early interventions and thereby avoid an accumulation of deficiencies, which is expected to reduce attrition rates.

In addition, all efforts are being made to change the CPE examination to become primarily a means for certification purposes and to fully operationalize the Continuous Comprehensive Evaluation (CCE) Scheme in all grades and schools. Essential learning as well as desirable learning competencies have been incorporated in the primary curriculum.

Measures will be taken to encourage pupils to stay in their catchment areas. To encourage this, post-HSC regional scholarships at the University of Mauritius will be offered.

Teachers, Deputy Head Teachers, Head Teachers, Inspectors are continually following in-service courses to upgrade the quality of teaching and monitoring. Human resource development is one of the objectives which has allowed heads of secondary and primary schools to be trained in Management. A computer centre at the Ministry has helped the training of all grades of officers in the use of a computer.

3. Secondary Education

Because secondary education may be terminal for some students and constitute their preparation for the labor market and/or prepare students for entry into higher education, the Government wants to assure that every child will be able to complete Nine Year Schooling.

On-going improvements in the primary subsector are causing an increase in the demand for access to secondary schools. The number of state secondary schools has increased from 22 in 1990 to 34 in 2000 constructed to meet this demand at the same time, loans at a low interest rate have been given to the private secondary schools to improve their infrastructure so that existing disparities can be eliminated.

Regionalisation is in due course to be seen as one major answer to address the intense competition for access to the secondary education, and while the process cannot be rushed without proper planning, specific steps are being taken in the short term to implement this strategy.

Presently about fifteen percent of secondary students are ill-equipped to fully satisfy the traditional examination-based demands of the curriculum and drop out, especially as from Form III. Yet, all have specific abilities and aptitudes which if channelled in the right direction through differentiated curriculum options could enable them to complete secondary education. Efforts will be made to allow different potentials of these children to develop so that they can mature without feeling any inadequacy, and acquire the competencies for their personal, economic and social growth as part of this secondary schooling. The ministry has improved and expanded the Basic Secondary Schools (schools for the drop-outs) which link the practical with the academic aspects into State Secondary Schools (Vocational) SSSV - Government is considering setting up an Integrated Secondary School which will provide different learning approaches for these students. The private sector, has as from year 2001, taken one class of those who have not passed

CPE along the same lines as the SSS (V). About 2,500 students have been taken on board.

The curriculum of all secondary schools, will have diversified options not only in relation to the world of work, but also to encourage students to develop an affinity to their socio-cultural environment and their overall self-development. In addition, specific efforts are being made to strengthening the teaching and learning of Science, Mathematics and Technology.

4. The Tertiary Sector

Major developments are envisaged in this sub-sector to make it capable of fulfilling the educational, cultural and economic ambitions of the nation, one which is to extend Mauritian influence in the region.

To satisfy the unmet demand for participation in higher studies, all avenues are being explored, including the development of a system of Distance Education, to improve access to higher education for all Mauritians. Also, since the country aspires to play a major role in the region, access to higher education through joint education ventures have been initiated.

The achievement of the educational mission of the tertiary institutions require on the right kind of research and learning environment. Research has been given a major boost, along with the development of an effective peer review and publishing program.

Higher education can not divorced from the reality of the world of work. Every attempt is made to explore the potential for joint research and development, consultancy, an contract initiatives, without neglecting the fostering of strong relationships between the tertiary and other education sectors.

Tertiary education in Mauritius are encouraged to develop mutually advantageous strategic alliances with international institutions and other overseas centres/orgnaisations. Among other things, this will facilitate the exchange of information, procedures and programs, as well as staff secondments and programs for staff development.

The University of Mauritius has undergone an expansion to allow the intake to grow by 50 % and a second university specialising in management and technology has been set up.

Society at large participates in the process of educational change.

Many private technical institutions have come up in the country to cater for the need to develop skills in technology. These are registered with the 'Industrial Training and Vocational Board' which looks into their programme.

1.3 Lessons learnt and major difficulties encountered

Many projects have been initiated to help overcome problems at school level: inclusion of ELC's and DLC's in the curriculum, the training of teachers, the introduction of CCE, the establishment of a system of monitoring school-based experience, etc.

While policies are defined by the Ministry, other educational institutions such as MIE or MES carry out the implementation, and inspectors look into the evaluation, teachers who are the principal actors do not feel that they have been party to any innovative move. There is much resistance on their part to carry out or trial new methods and new information. Unions very often support them rendering the situation more difficult.

In the field of education, team worked is not part of the culture. Some projects which had started in 1992 or 1993 have died, for example an Education Management Information System has not been set up in spite of the fact that the Ministry has a Statistics Division. The National Inspectorate, in spite of the work carried out by a consultant has not been set up.

In ten years, the Ministry of Education has had four Ministers and technicians have had to adjust to different requirements. Although the issues to be fundamentally addressed are the same, the order of priorities underwent change. Consequently the orientation of various projects has changed.

Main problems and challenges

The involvement of the community in the field of education has seen an increase of pressure on schools to perform 'better', so that Mauritius is now facing a problem of value related to institutions. There are 'star' schools

(primary and secondary) which attract and others considered low-achieving which people resent; parents find all means not to send their children to these low-achieving schools although the physical infrastructure may be good. Teachers need to be given some financial incentive to work in these schools. It is evident that mostly children from low-income families attend these schools. The social stigma around such schools is very strong.

Much effort is being deployed to bridge the gap between these two categories of schools.

The CPE (last examination at the end of the primary cycle) acts as a stumbling block to the concept of overall education. Children undergo much stress because they have to score high marks to have access to the 'star' colleges. Parents and teachers concentrate all attention on academic performance and neglect the emotional and psychological development of the child.

A minimum of 30 % of children come out of the system practically illiterate. The 9 to 11 year school may reduce this percentage by providing them with technical subject in the formal system.

The Ministry hopes to break this vicious circle by providing more colleges in region and by bringing diversity in the curriculum to allow the balance between the logic and aesthetic aspects.

The objectives of the curriculum are not well-defined to allow it to adjust quickly to changes in information and technology.

Attending primary school has been made compulsory; however, there are still cases of children who do not attend school for various reasons, one of them being that they do not have a birth certificate and procedures for the obtaining of one is a long legal process. The Ministry of Education is working closely with Ministry for Women's Rights and Family Welfare to remedy this situation.

2.1 Curriculum development, principles and assumptions

(a) The decision-making process

Decisions about curriculum issues are taken following new trends and weaknesses identified in pupils' achievement. While the policy is established by the Ministry of Education, the formulation is done by the Mauritius Institute of Education through the preparation of Curriculum Guidelines within a framework. The National Centre for Curriculum produces the learning material as well as teacher's guides. The evaluation is carried out through reactions and suggestions from all parties concerned.

(b) Curriculum planning and design

The basic assumptions and general principles of the existing curriculum are related to the fact that children attending school must develop skills and aptitudes to be able to be full integrated members of society. Hence, the primary curriculum ensures basic education, namely communication, numeracy and literacy while the secondary provides the general basis for training in specific skills as well as leads towards appropriate studies.

The different types of knowledge are selected along these lines and organised in an order of priority, taking into consideration the core knowledge—languages, maths, health and the peripheric which allows flexibility for artistic and aesthetic activities. Teachers are trained to integrate subjects to make teaching wholesome.

(c) Teaching and learning strategies

Various methods (including the communicative and spiral approaches) are used to strengthen the inter-relatedness between teaching and learning. Students are encouraged to do team work, to prepare projects; very often the physical lay out of the class is changed to adapt to interaction among students. Real-life situations are most of the time the starting point of lessons. Teachers are familiar with the concept of participative role of students, being trained during their pre-service and in-service courses.

(d) Assessment policies and instruments

Standards are fixed by grades approved at national level (A to E for pass and F being a failure or 1 - 6 (credit) and 7 - 8 (pass) and 9 (fail)), following the British system.

Standards at school level are set by the Ministry; however heads of schools have a margin of flexibility to increase or decrease; most tend to follow the same pattern as the national examinations.

Children who do not meet the standards are provided with some form of remedial education; a low percentage of parents ask for their ward to repeat in order to improve their results.

Schools normally have 39 school weeks (13 per term) and teaching periods vary from 30 to 40 minutes each.

2.2 Changing and adapting educational content

- (a) With new social and technological at international and national level, the curriculum demands to be reviewed and adjusted. New elements are added.
- (b) The Mauritius Examinations Syndicate draws attention to the weaknesses in the performance of students through their analysis of results of national examinations. This information is disseminated to all stakeholders who propose changes or adjustments in the content of the curriculum.
- (c) New disciplines as well as new topics are worked out following crucial issues which have an impact on life in Mauritius, such as health, civic education, environment preservation, etc.
- (d) Strategies are related to new educational trends which are adapted to the Mauritian context; the National Curriculum Centre has different panels for different disciplines to prepare materials. The material is trialled before being fully implemented.
- (e) The curriculum material, in terms of educational content and methodologies used, has translated the concept of universal education into reality. All primary school children are provided freely with textbooks, thus ensuring equity in education.

Achievements, problems and solutions adopted; urgent issues ...

- (f) New topics have been gradually introduced so that to-day the curriculum contains practically all the elements which allow the acquisition and

consolidation of attitudes and skills and which help shape the personality of individuals.

Information technology is being introduced in the lower classes of the primary cycle.

However, most of the learning is geared towards examinations and there is the tendency to neglect all non-examinable subjects. The emotional and psychological development although visible in the curriculum is not a concern in the classroom. Hence, all learning is mostly memorisation of facts for the scoring of high marks. Educational reforms will lay more emphasis on the creative and aesthetic aspects of education to ease out the competition at the end of the primary cycle, by having these subjects on the time table and by recruiting specialist teachers for the specific subjects. Music and art will become an essential part of the curriculum.

In the field of education, Mauritius has for quite long been facing a major problem: What language to be used and when? The fight has for long been between English and French and over the last ten years, Asian Languages have grown in importance. There is a demand for more contact hours in these languages.

The urgent issue being tackled is the unloading of the primary curriculum and the introduction of subjects which will bring the balance between the logical and the emotional intelligences.



Apollo Bramwell Nursing School

Batch 5

NURS 1007 Information Technology and Communication Skills

Presentation and Submission: 12.05.2014

Batch 5

Oral Presentation

15 Minutes Presentation

(15 MARKS)

The class will be divided into five groups. Each group needs to do a Fifteen minutes classroom presentation.

There are Six distinct components to this Oral Examination, see below:

- PowerPoint Presentation : 2 Marks
- Reading : 2 Marks
- Coherence of ideas : 2 Marks
- Discussion : 3 Marks
- Research Materials used : 3 Marks
- Answering of Questions : 3 Marks



Counseling Assignment for Batch V

Mr. Chottoo Aubdool

1. Auckbur Anne Emilie Lisa
2. Beekhory Muhammad Shameem
3. Dinmahamed Sumaiyah
4. Khodabux Amiirah Bibi
5. Lallbeeharry Inshduth Chris
6. Ragoobar Laval Vicky

Mr. Bryan Mae Degorio

1. Balchand Manisha
2. Dookhurrun Sanjeena
3. Dwarika Mahkeshav
4. Khoyratty Noorani
5. Mohabul Ishaie
6. Ramgoolam Vijayaluxmi

Mr. Feizal Chadee

1. Boodhun Upashna
2. Duval Marie Julietta Nadine
3. Fokeer Shiksha Chivanee
4. Kurrooman Shandisha Devi
5. Mungur Parveshsing
6. Soodin Samsoundar Gavin

Mr. Moh Taher

1. Bucha Keshwan Kritama
2. Fokeer Shiksha Chivanee
3. Goolam Mamode Luqmaan
4. Nahaboo Solim Hanaa
5. Padaruth Kevin
6. Suharye Yudish

Mrs. Alith Nathoo

1. Coolen Mewenavadee
2. Hanooman Ashwinee
3. Jugmohun Keshav
4. Pargass Soumitradevi
5. Permal Beija Orly
6. Silavente Julia

Aboo B.S.Fatally ABNS1405011
Recitation Globalisation with ChotAub

Demystifying the word [R]E -Citation

background knowledge, and practical skills. Maynard (1996) used Benner's model to examine the relationship between a nurse's critical thinking ability and professional competence.

Madeleine M. Leininger: Culture Care: Diversity and Universality Theory—1985

The Theorist

MADELEINE M. LEININGER was born in Sutton, Nebraska. She received a diploma in 1948 from St. Anthony's Hospital School of Nursing in Denver and served in the Cadet Nurse Corps while pursuing her basic nursing education. She earned a bachelor's in biological science from Benedictine College in Kansas in 1950 and, after completing advanced study in nursing at Creighton University in Omaha, a master's in psychiatric nursing from Catholic University of America in Washington, DC. She was the first nurse to study anthropology at the doctoral level, earning her PhD from the University of Washington, Seattle, in 1965. She currently lives in Omaha, Nebraska.

In the mid-1950s, when Leininger was working in a child guidance home in Cincinnati, she discovered that staff did not understand the cultural factors that influenced the behavior of children. She concluded that nursing decisions and actions did not help children adequately. This experience stimulated her to pursue a doctoral study in anthropology. Her early writings, beginning in the late 1970s, focused on caring and transcultural nursing. She continued to write about these areas before publishing her theory on culture care diversity and universality in its entirety (Leininger, 1985, 1988).

Leininger has held positions in nursing education and administration, serving as dean of nursing at the universities of Washington and Utah. She was director of the Center for Health Research at Wayne State University in Michigan until she retired as professor emeritus. In addition to studying in New Guinea during her doctoral study, she has studied 14 other cultures in depth. She is the founder and leader of the field of transcultural nursing and has served as a consultant on transcultural nursing and her theory of culture care around the globe. She established the *Journal of Transcultural Nursing* in 1989 and served as editor for six years. She has numerous honorary degrees and other national awards and has served as visiting professor or lecturer in 10 or more countries.

The Theory

The conceptual and theoretical framework for Leininger's culture care diversity and universality theory was laid out in her early writings about transcultural nursing, but was not published until 1985. Initially, Leininger focused on the importance of caring in nursing and became aware of the special needs of children with different cultural backgrounds. Transcultural nursing, as this subfield of nursing practice and research is known, focuses on the cultural values, beliefs, and practices of individuals and groups with the goal of providing culture-specific care (George, 2002). Both the nurse and the client are considered.

Leininger's theory includes 14 concepts, 10 labeled as "major" and 4 as "other." The concepts she shares most frequently with other theorists are care, caring, health, and nursing, but those that are most distinctive to her theory are culture care, diversity, universality, worldview, and ethnohistory. Leininger developed the sunrise model to help nurses visualize the components of the culture care theory. The model is a cognitive map that moves from the most abstract to the least abstract and provides a holistic and comprehensive conceptual picture of the important factors in the theory. The top of the map provides the worldview and social system level, which directs the study of perceptions of the world outside of the culture (Fig. 7.4).

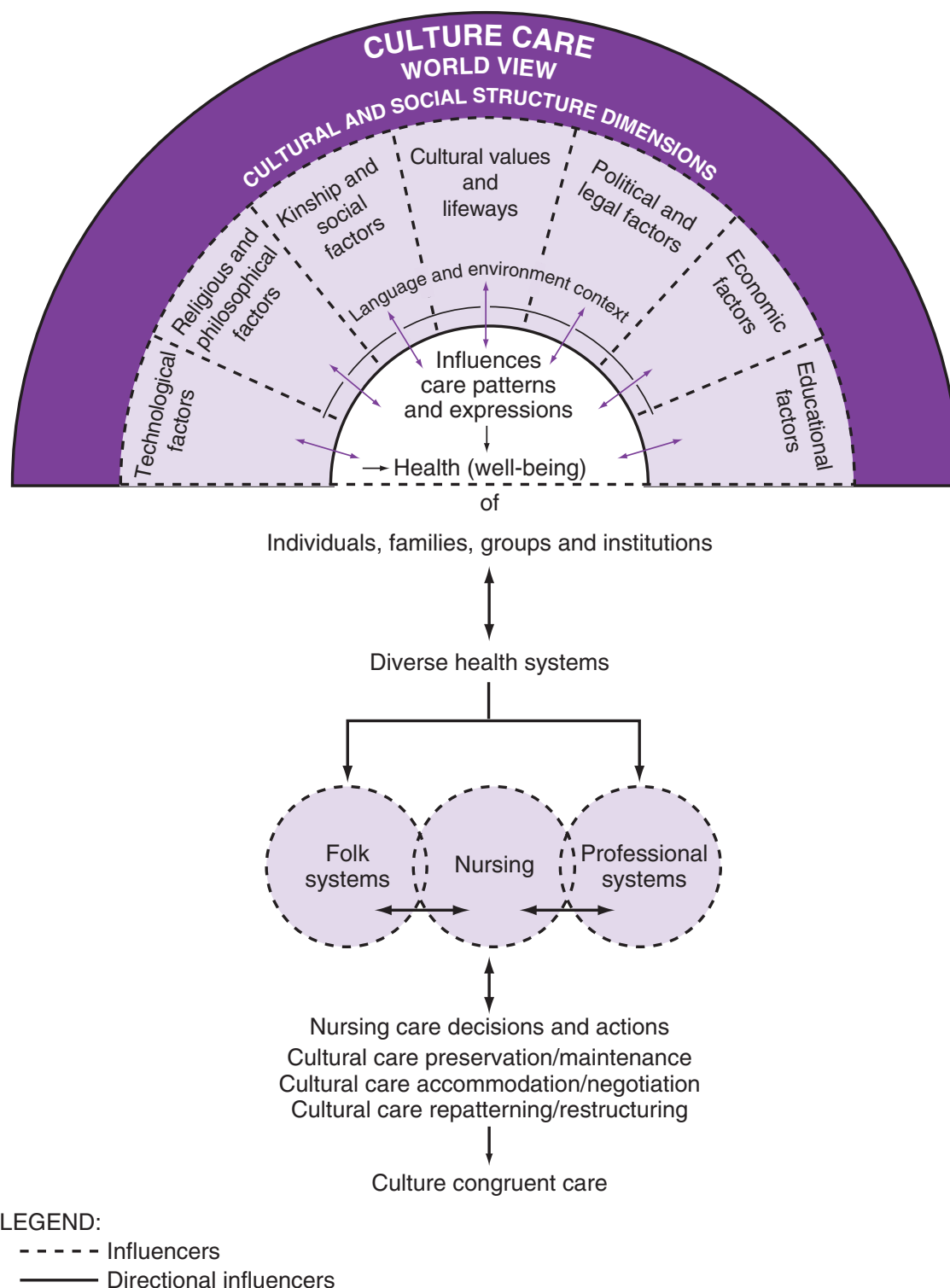


Figure 7.4 Leininger's sunrise model depicts dimensions of culture care diversity and universality. (From Leininger, M. M. [Ed.]. [1991]. *Culture care diversity and universality: A theory of nursing* [p. 43]. New York: National League for Nursing Press. Used with permission.)

Leininger continues to revise and refine her theory and is actively involved in identifying concepts and phenomena for study. She assists graduate students and others to use her framework for designing their research. Although nurses credit Watson with inventing the caring movement, Leininger played a significant role in bringing the caring concept to the nursing community in the mid-1960s (Leininger, 1977) (Box 7.20).

Box 7.20 Summary of Leininger's Culture Care Diversity and Universality Theory

Phenomenon: Every individual and group belongs to a culture or subculture that has specific beliefs and values that influence nursing care.

Idea: Effective nurses provide culturally relevant care.

Key Concepts/Internal Variables

Culture: "The learned, shared, and transmitted knowledge of values, beliefs, norms, and lifeways of a particular group that guides an individual or group in their thinking, decision, and actions in patterned way" (Leininger, 1985, p. 210).

Culture Care: The subjectively and objectively learned and transmitted values, beliefs, and patterned lifeways that assist, support, facilitate, or enable an individual or group to maintain well-being and health, to improve the human condition and lifeway, or to deal with illness, handicaps, or death.

Diversity: The variables and/or differences in the ways that cultures perceive, know, and practice health and nursing care.

Universality: The commonalities in the ways that cultures share the perceptions, knowledge, and practices related to health and nursing care.

Worldview: The way people look at the world or the universe and form a "picture or value stance" about the world and their lives (Leininger, 1985, p. 105).

Ethnohistory: "Past facts, events, instances, and experiences of individuals, groups, cultures, and institutions that are primarily people-centered (ethno) and that describe, explain, and interpret human lifeways within a particular culture over periods of time" (Leininger, 1985, p. 106).

Examples of Propositions

Culture-specific caring actions lead to improved health and well-being of individuals.

Economics, religion, and kinship ties of a culture influence healthcare patterns.

Nursing and healthcare that is culturally congruent has a favorable impact on health and well-being.

Examples of Assumptions

Healthcare is shaped by the individual's or group's cultural values, beliefs, and practices.

The central purpose of nursing is to serve human beings worldwide.

Beneficial, healthy, and satisfying culturally based nursing care contributes to the well-being of individuals, families, groups, and communities within their environmental context.

Examples of External Variables

The use of universal procedures and techniques

Healthcare that is shaped by textbooks

Mass production of healthcare

Examples of Facts, Principles, and Laws

Fact: Human beings belong to different cultures and subcultures.

Principle: Cultures have specific values and beliefs about health and healthcare.

Law: Cultural values and beliefs influence health behavior.

Influence of Leininger's Culture Care: Diversity and Universality Theory

Education The impact of culture care preceded the 1985 introduction of Leininger's theory. Leininger introduced the concepts of cultural care at the undergraduate level in 1966 and at the master's and doctoral levels in 1977. There are few, if any, nursing programs that do not recognize the impact of culture on nursing care, even though they may not give credit to the theory. Leininger's theory has made an enormous impact on how nursing is taught around the world; however, she is concerned that few programs use it as a major focus. Her global influence on education has been significant, with presentations and consultations on every continent and in innumerable countries (Tomey & Alligood, 2002).

Practice. As the world becomes smaller and populations shift, neighborhoods become more diverse, and there is a need to consider cultural backgrounds of patients in your decisions about nursing care. When you travel outside the country or even your community, you will be exposed to ideas that are different from those you learned and practiced as a child. When you look at patients, you see things you would not have noticed prior to Leininger's work. Your patients may look different, speak a different language, eat different foods, worship different gods, wear different clothes, use different standards of daily hygiene, and care for the ill and elderly in different ways. For example, in some countries, a family member sleeps on a mat under the patient's hospital bed; in others, family members provide the food the patient eats. The culture care diversity and universality theory has been applied universally and affects nursing care significantly worldwide, including Australia, Canada, Germany, India, Japan, Sweden, New Zealand, and the United Kingdom. In the United States, transcultural practice has included such culturally diverse communities as African American, African American elderly, the deaf, Hispanic, Japanese American, Lithuanian American, Mexican American, Navajo, and Vietnamese (George, 2002).

Research. Leininger's theory has enjoyed global recognition in terms of research. The development of the theory over a long period has allowed it to be tested in many cultures. It is the only theory that speaks specifically to cultural needs with a research method to examine the theory, ethnonursing. By 1995, over 100 cultures and subcultures had been studied, with many more in progress (Tomey & Alligood, 2002). Two examples illustrate the type of research and results.

An ethnographic study was conducted of family vigilance in two acute care neurological units. Informal, semistructured interviews and participant observation of family members were used to collect data. All subjects except one stayed with their family members for 24 hours. Participants were asked to talk about their reasons for staying. Data were compiled into five categories: commitment to care, emotional upheaval, dynamic nexus (changing family relationships), transition, and resilience. The findings affirm substantive knowledge that expands the understanding of vigilance as a caring expression and contributes to the body of knowledge about culture care (Carr, 1998).

The purpose of the second study was to identify and analyze the care expressions, practices, and patterns of elderly Anglo-American and African American residents in a long-term care institution using the ethnonursing qualitative research method. Data gathered from 40 participants, including residents and nursing staff, provided four themes: maintenance of pre-admission lifestyles, professional care that was beneficial and satisfying to residents, major differences between apartment and nursing home residents, and an institutional culture that reflected patterns and practices of care. The findings are useful to the residents and professional staff, as well as for elaborating on the culture care diversity and universality theory (McFarland, 1997).

Jung Typology Test™

This free test is based on Carl Jung's and Isabel Briggs Myers' typological approach to personality*.

Upon completion of the questionnaire, you will:

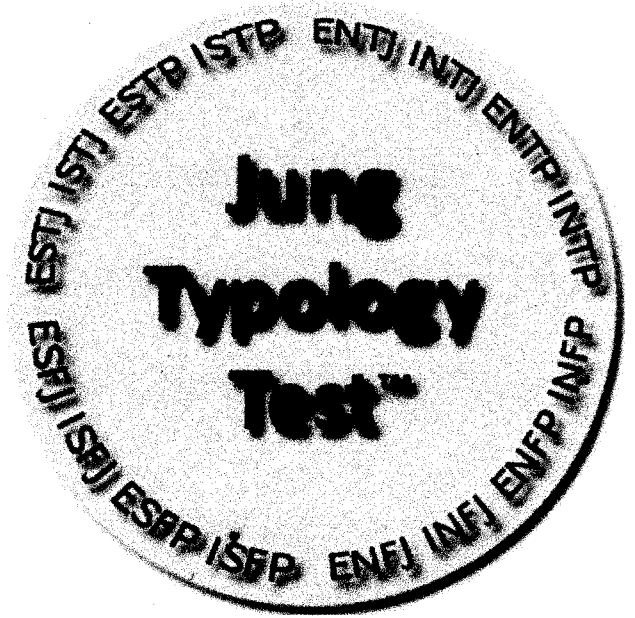
- ✦ Obtain your 4-letter type formula according to Carl Jung's and Isabel Briggs Myers' typology, along with the strengths of preferences and the description of your personality type
- ✦ Discover careers and occupations most suitable for your personality type along with examples of educational institutions where you can get a relevant degree or training
- ✦ See which famous personalities share your type
- ✦ Access free career development resources and learn about premium ones
- ✦ Be able to use the results of this test as an input into the Jung Marriage Test™ and the Demo of the Marriage Test™, to assess your compatibility with your long-term romantic partner

Instructions: When responding to the statements, of the two responses please choose the one you agree with most. If you are not sure how to answer, make your choice based on your most typical response or feeling in the given situation. To get a reliable result, please respond to all questions. When you are done with answering, press the "Score It!" button at the bottom of the screen. **Scroll down to the questionnaire!**

* Humanmetrics Jung Typology Test™ instrument uses methodology, questionnaire, scoring and software that are proprietary to Humanmetrics, and shall not be confused with the MBTI®, Myers-Briggs® and/or Myers-Briggs Type Indicator® instrument offered by CPP, Inc. Humanmetrics is not affiliated with CPP, Inc.

1. You are almost never late for your appointments
☐ YES ☐ NO
2. You like to be engaged in an active and fast-paced job
☐ YES ☐ NO
3. You enjoy having a wide circle of acquaintances

- ☐ YES ☐ NO
4. You feel involved when watching TV soaps
☐ YES ☐ NO
 5. You are usually the first to react to a sudden event, such as the telephone ringing or unexpected question
☐ YES ☐ NO
 6. You are more interested in a general idea than in the details of its realization
☐ YES ☐ NO
 7. You tend to be unbiased even if this might endanger your good relations with people
☐ YES ☐ NO
 8. Strict observance of the established rules is likely to prevent a good outcome
☐ YES ☐ NO
 9. It's difficult to get you excited
☐ YES ☐ NO
 10. It is in your nature to assume responsibility
☐ YES ☐ NO
 11. You often think about humankind and its destiny
☐ YES ☐ NO
 12. You believe the best decision is one that can be easily changed
☐ YES ☐ NO
 13. Objective criticism is always useful in any activity
☐ YES ☐ NO
 14. You prefer to act immediately rather than speculate about various options
☐ YES ☐ NO
 15. You trust reason rather than feelings
☐ YES ☐ NO
 16. You are inclined to rely more on improvisation than on prior planning
☐ YES ☐ NO
 17. You spend your leisure time actively socializing with a group of people, attending parties, shopping, etc.
☐ YES ☐ NO
 18. You usually plan your actions in advance
☐ YES ☐ NO
 19. Your actions are frequently influenced by emotions
☐ YES ☐ NO
 20. You are a person somewhat reserved and distant in communication
☐ YES ☐ NO
 21. You know how to put every minute of your time to good purpose
☐ YES ☐ NO
 22. You readily help people while asking nothing in return
☐ YES ☐ NO
 23. You often contemplate the complexity of life
☐ YES ☐ NO
 24. After prolonged socializing you feel you need to get away and be alone



ADVERTISEMENT

☐ YES ☐ NO

25. You often do jobs in a hurry

☐ YES ☐ NO

26. You easily see the general principle behind specific occurrences

☐ YES ☐ NO

27. You frequently and easily express your feelings and emotions

☐ YES ☐ NO

28. You find it difficult to speak loudly

☐ YES ☐ NO

29. You get bored if you have to read theoretical books

☐ YES ☐ NO

30. You tend to sympathize with other people

☐ YES ☐ NO

31. You value justice higher than mercy

☐ YES ☐ NO

32. You rapidly get involved in the social life of a new workplace

☐ YES ☐ NO

33. The more people with whom you speak, the better you feel

☐ YES ☐ NO

34. You tend to rely on your experience rather than on theoretical alternatives

☐ YES ☐ NO

35. As a rule, you proceed only when you have a clear and detailed plan

☐ YES ☐ NO

36. You easily empathize with the concerns of other people

☐ YES ☐ NO

37. You often prefer to read a book than go to a party

☐ YES ☐ NO

38. You enjoy being at the center of events in which other people are directly involved

☐ YES ☐ NO

39. You are more inclined to experiment than to follow familiar approaches

☐ YES ☐ NO

40. You avoid being bound by obligations

☐ YES ☐ NO

41. You are strongly touched by stories about people's troubles

☐ YES ☐ NO

42. Deadlines seem to you to be of relative, rather than absolute, importance

☐ YES ☐ NO

43. You prefer to isolate yourself from outside noises

☐ YES ☐ NO

44. It's essential for you to try things with your own hands

☐ YES ☐ NO

45. You think that almost everything can be analyzed

☐ YES ☐ NO

46. For you, no surprises is better than surprises - bad

or good ones

☐ YES ☐ NO

47. You take pleasure in putting things in order

☐ YES ☐ NO

48. You feel at ease in a crowd

☐ YES ☐ NO

49. You have good control over your desires and temptations

☐ YES ☐ NO

50. You easily understand new theoretical principles

☐ YES ☐ NO

51. The process of searching for a solution is more important to you than the solution itself

☐ YES ☐ NO

52. You usually place yourself nearer to the side than in the center of a room

☐ YES ☐ NO

53. When solving a problem you would rather follow a familiar approach than seek a new one

☐ YES ☐ NO

54. You try to stand firmly by your principles

☐ YES ☐ NO

55. A thirst for adventure is close to your heart

☐ YES ☐ NO

56. You prefer meeting in small groups over interaction with lots of people

☐ YES ☐ NO

57. When considering a situation you pay more attention to the current situation and less to a possible sequence of events

☐ YES ☐ NO

58. When solving a problem you consider the rational approach to be the best

☐ YES ☐ NO

59. You find it difficult to talk about your feelings

☐ YES ☐ NO

60. You often spend time thinking of how things could be improved

☐ YES ☐ NO

61. Your decisions are based more on the feelings of a moment than on the thorough planning

☐ YES ☐ NO

62. You prefer to spend your leisure time alone or relaxing in a tranquil atmosphere

☐ YES ☐ NO

63. You feel more comfortable sticking to conventional ways

☐ YES ☐ NO

64. You are easily affected by strong emotions

☐ YES ☐ NO

65. You are always looking for opportunities

☐ YES ☐ NO

66. Your desk, workbench, etc. is usually neat and orderly

☐ YES ☐ NO

67. As a rule, current preoccupations worry you more than your future plans
☐ YES ☐ NO
68. You get pleasure from solitary walks
☐ YES ☐ NO
69. It is easy for you to communicate in social situations
☐ YES ☐ NO
70. You are consistent in your habits
☐ YES ☐ NO
71. You willingly involve yourself in matters which engage your sympathies
☐ YES ☐ NO
72. You easily perceive various ways in which events could develop
☐ YES ☐ NO

Your age: ÷ Gender: ÷

Score It!

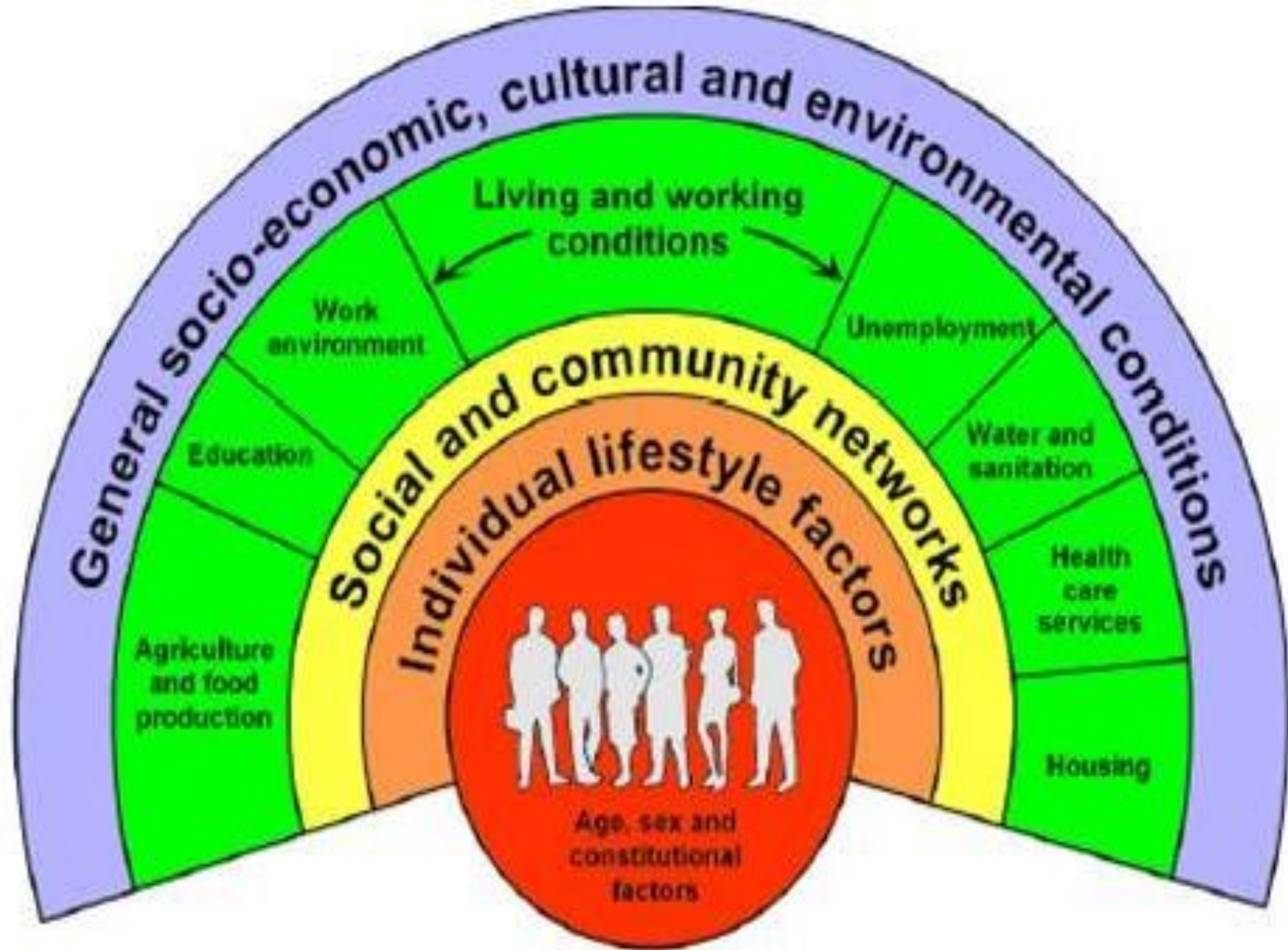
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Determinants of Health

Aim: Learners will have an understanding of the holistic concept of health.

Objectives:

- ❖ Learners will analyze the relationship between socio-cultural, economic and political trends and the health of individuals and families.
- ❖ Learners will be able to list the determinants of health and its impact on individual and society.

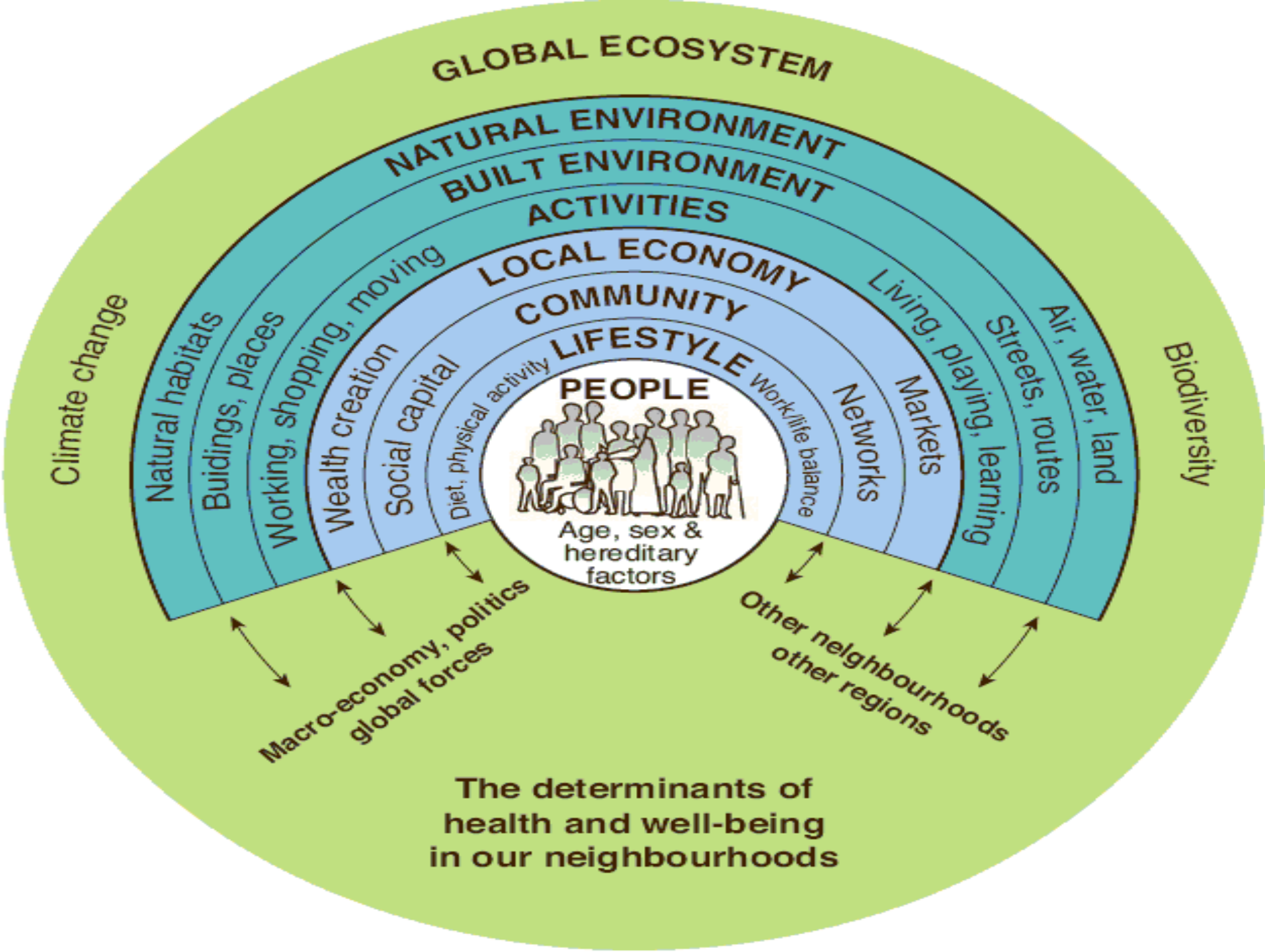
The determinants of health include:

- ❖ The social and economic environment
- ❖ The physical environment and
- ❖ The person's individual characteristics and behaviors.

The context of people's lives determine their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants—or things that make people healthy or not—include the above factors, and many others:

The determinants of health

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.



Social determinants of health are the conditions in which people are born, grow up, live, work and age. These conditions influence a person's opportunity to be healthy, his/her risk of illness and life expectancy. Social inequities in health – the unfair and avoidable differences in health status across groups in society – are those that result from the uneven distribution of social determinants.

Social determinants of health and health inequities are amenable to change through policy and governance interventions.

Over the last century, average health status improved in Europe. However, these gains are not evenly distributed across countries or across social groups within the same country.

Health inequities can be observed in higher and lower income countries alike across the WHO European Region.

Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.

Health services - access and use of services that prevent and treat disease influences health

Gender - Men and women suffer from different types of diseases at different ages.

Education – low education levels are linked with poor health, more stress and lower self-confidence.

Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health.

Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions

Social support networks – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.

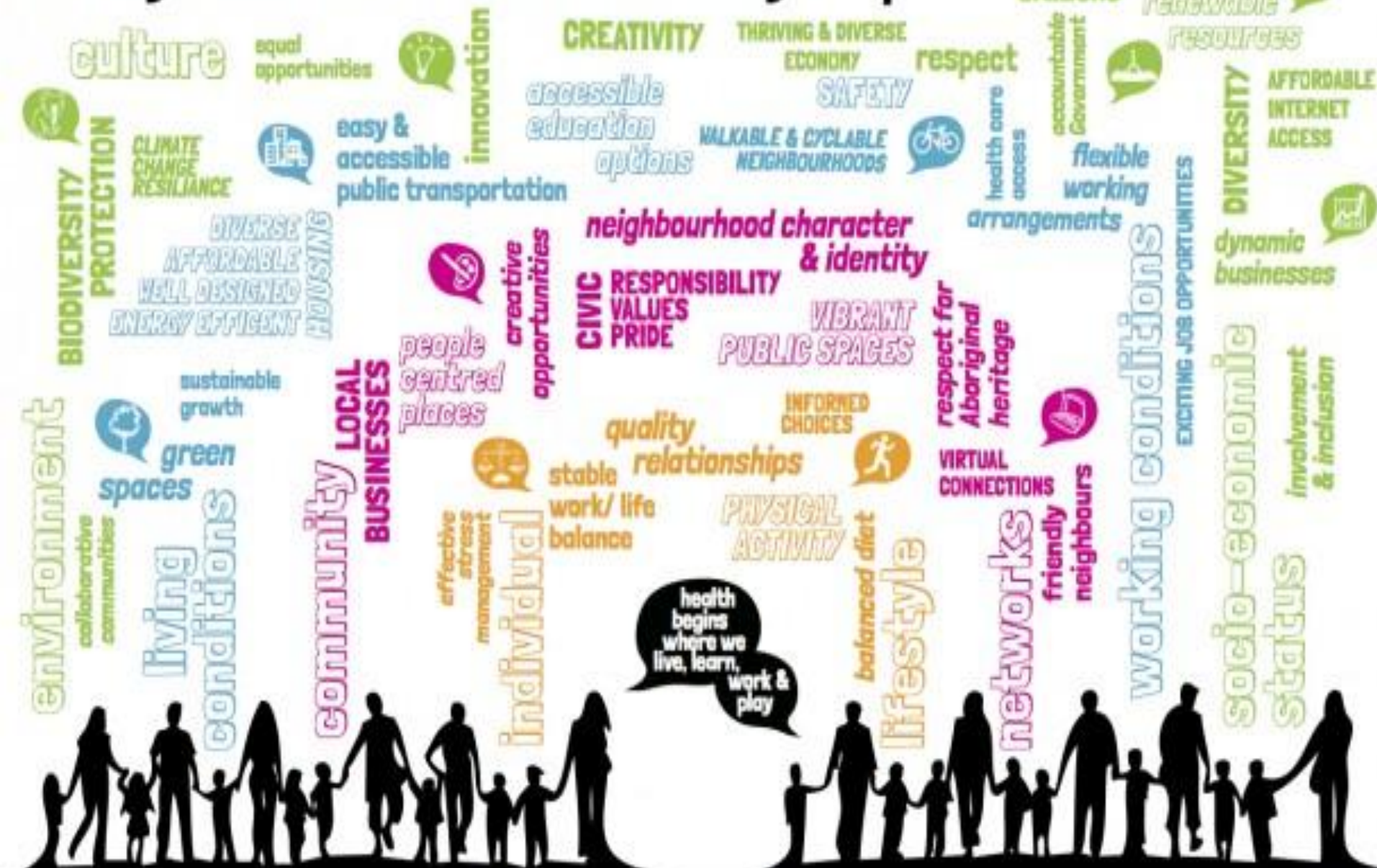
Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses.

Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.

- Alcohol use
- Health Systems Financing
- Housing and Health
- Maternal and newborn health
- Millennium Development Goals
- Occupational health
- Public health services
- Urban Health
- Water and Sanitation.

Poverty is a key factor in explaining poorer levels of health between the most and least well-off countries and population groups within the same country. Yet differences in health also follow a strong social gradient. This reflects an individual or population group's position in society, which translates in differential access to, and security of, resources, such as education, employment, housing, as well as differential levels of participation in civic society and control over life.

empowered
citizens



As part of our work in South Australia between 2010–2012, we heard from people living in metropolitan Adelaide about their vision for the future. Dahlgren & Whitehead's Social Determinants of Health Model (1991) provides a good basis to provide a summary of the key themes the community identified as important.

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Alcohol intake in the WHO European Region is the highest in the world. Harmful use of alcohol is related to premature death and avoidable disease and is a major avoidable risk factor for neuropsychiatric disorders, cardiovascular diseases, cirrhosis of the liver and cancer.

It is associated with several infectious diseases, such as HIV/AIDS and tuberculosis, and contributes significantly to unintentional and intentional injuries, including those due to road traffic accidents and suicide. Further, excessive alcohol use during a woman's pregnancy can lead to severe mental handicap

All Member States face difficult challenges and choices in financing their health systems. New medicines and other technological developments continually expand the range of health problems that can be treated, while ageing populations and rising expectations create upwards pressure on costs which stretch the limits of countries' ability to find adequate funding.

Macroeconomic, demographic and fiscal capacity constrains governments in allocating more public revenue for the health system. As a result, all countries – whether high, medium or low income – seek to improve the organization of health system financing.

Housing conditions affect people's health. Inadequate housing causes or contributes to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer.

Poor design or construction of homes is the cause of most home accidents. In some European countries, they kill more people than do road accidents.

Use of proper building materials and construction could prevent indoor pollutants or mould, causing asthma, allergies or respiratory diseases. About every tenth lung cancer case results from radon in the home. Appropriate design can prevent both exposure and the risk to health.



1

ERADICATE
EXTREME POVERTY
AND HUNGER



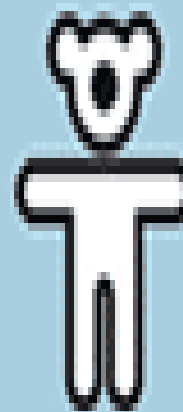
2

ACHIEVE UNIVERSAL
PRIMARY EDUCATION



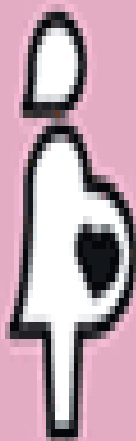
3

PROMOTE GENDER
EQUALITY AND
EMPOWER WOMEN



4

REDUCE
CHILD MORTALITY



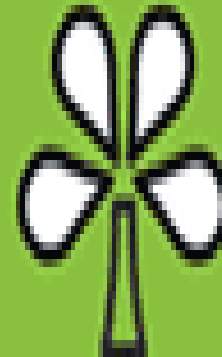
5

IMPROVE
MATERNAL HEALTH



6

COMBAT HIV / AIDS,
MALARIA AND OTHER
DISEASES



7

ENSURE
ENVIRONMENTAL
SUSTAINABILITY



8

GLOBAL
PARTNERSHIP FOR
DEVELOPMENT

The United Nations Millennium Declaration, adopted in 2000 by 189 nations, embraces a vision for a world in which countries work in partnership for the betterment of all, particularly the most disadvantaged. This vision was transformed into eight Millennium Development Goals (MDGs) and, since then, a total of over 20 targets and 60 indicators.

Three of the goals are health-specific, addressing child health (MDG 4) and maternal health (MDG 5) and combating HIV/AIDS, malaria and other diseases including tuberculosis (MDG 6).

Poverty is a key factor in explaining poorer levels of health between the most and least well-off countries and population groups within the same country. Yet differences in health also follow a strong social gradient. This reflects an individual or population group's position in society, which translates in differential access to, and security of, resources, such as education, employment, housing, as well as differential levels of participation in civic society and control over life.

The other goals address key determinants of health including poverty and hunger, gender equality, environmental sustainability, and global partnership for development.

Determinants of Health

Income and
Social Status

Social
Support
Networks

Education

Employment
and Working
Conditions

Physical
Environments

Biology and
Genetics

Personal
Health
Practices and
Coping Skills

Healthy
Child
Development

Health
Services
and Social
Services

Social
Environments

Gender

Culture

Thank
You!



APOLLO BRAMWELL NURSING SCHOOL

Module: Nursing Theory and Practice 1 (NURS 1001)

Subject: Safety and security needs

Level: Semester 1/ Year 1 Diploma in Nursing Studies

Assignment : (100%)

Submission Date: 12/5/2014

Late Submission of assignment without good and valid reason will entail deduction of marks.

Instructions:

- Write an essay of 1000 words
- Marks will be deducted for improper use of the English Language grammar and punctuation.
- Preferred typed

Topic.

- Safety and security of patient are vital in hospital environment.
 - As a student nurse how would you identify high risk patient and what safety measures can be considered and implemented.

From: Feizal Chadee fchadee@apollobramwellnursingschool.com

Subject: guidelines for assignment

Date: May 5, 2014 at 1:00 PM

To: Auckbur Lisa lisaaukbur@live.com, Balchand Manisha msoophul@yahoo.com, Beekhory Shameem shameembeekhory@hotmail.co.uk, Boodhun Upashna booms73@live.com, Bucha Keshwan keshwanbuchact@hotmail.com, Coolen Mewenavadee mefishacoo@myt.mu, Dinmahamed Sumaiyah wondersumy@live.com, Dookhurrin Sanjeena sanjeena.dookhurrin@yahoo.co.uk, Duval Julietta juliestarla1993@hotmail.com, Dwarika Mahkeshav mahkeshav.dwarika@yahoo.com, Fatally Aboo aboo.b.s.fatally@live.com, Fokeer Shiksha shikshafokeer@hotmail.com, Gavin Soodin gavinsoodin@yahoo.com, Goolam Mamode Luqmaan luqonly@hotmail.com, Hanooman Ashwinee ashshaha21@hotmail.co.uk, Jugmohun Keshav keshelvi1519@gmail.com, Khodabux Amiirah amirosekandpal@yahoo.com, Khoyratty Noorani noorani91@hotmail.fr, Kurrooman Shandisha vitisha.kurrooman@gmail.com, Lallbeeharry Chris chrislallbeeharry@gmail.com, Mohubal Ishaie micro_eyes_11@yahoo.com, Mungur Parveshsing mungurkevin@yahoo.com, Nahaboo Solim Hanaa hanaa.solim@live.com, Padaruth Kevin kev_4400@live.fr, Pargass Somitradevi ppargass@yahoo.com, Ragoobar Laval maeel@hotmail.com, Vicky Ragoobar lragoobar@apollobramwell.com, Ramgoolam Vijayaluxmi ashna14ramgoolam@gmail.com, Silavente Julia silavente_julia@yahoo.com, Suharye Yudish yudishsuharye19@gmail.com

Dear all,

Please find attachment with regards to assignment.

All the best

Mr Feizal

Feizal Chadee
Clinical Instructor

We take care of those who take care of you
Nous prenons soin de ceux qui prennent soin de vous

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Nursing

hw 3/24

02-05

hiko Surg

1. Inflammation

2.

Tissues H

A. Fungus S

R. Bacteria S

C. Virus S

D. Parasite S

Theorem - Uniform hypothesis -

Inflammation

Fungus

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Bionics to Track Your Health

Implants as Thin as Tattoos and Devices That Dissolve in the Body

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By ROBERT LEE HOTZ

CONNECT

April 21, 2014 5:46 p.m. ET

At laboratories in the U.S., Switzerland, and Korea, bioengineers are developing unusually flexible ultrathin electronics that promise to free medical diagnostics from the clinical tethers of cables and power cords, to make the mechanics of measuring vital signs more intimate. Robert Lee Hotz reports.

Imagine a digital tattoo that transmits skin temperature; a transparent sensor on a contact lens that tests for glaucoma; a pliable pacemaker wrapped around a beating heart; and an implant that controls pain after surgery, then dissolves harmlessly when it is no longer needed.

Each one is an experiment under way today in the biophysics of personal medicine.

At laboratories in the U.S., Switzerland, and Korea, bioengineers are developing unusually flexible ultrathin electronics that promise to free medical diagnostics from the clinical tethers of cables and power cords, to make measuring vital signs more intimate and effective. Unlike today's rigid computer semiconductor chips, these bionics are designed to stretch, fold and bend without breaking. They are curvy and soft like much of the body itself.

"It is such a different way of thinking about electronics, making things stretchy," said material scientist John A. Rogers at the University of Illinois at Urbana-Champaign who helped pioneer the technology. "There are a lot of things in human health care that we could do with these that are impossible today."

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A tattoo-like electronic thermometer from Northwestern University and the University of Illinois at Urbana-Champaign. *Beckman Institute/University of Illinois at Urbana-Champaign*

Rudimentary soft sensors are already edging into the market, incorporated into wrist bands that track exercise heart rate or as a wearable patch to sense head impact among athletes.

As more sophisticated medical applications become available during the next decade, these wireless devices will allow doctors and patients to monitor key health signs continuously, rather than only during periodic office or clinic visits, researchers said.

"It changes the game somewhat," said biomedical engineer Fiorenzoomenetto at Tufts University in Medford, Mass., who is among those developing biocompatible and biodegradable electronic medical devices.

It may be a decade before flexible electronic implants are approved for human use, but the digital skin patches promise to make vital sign monitors more portable and less obtrusive. Dr. Rogers and his colleagues reduced the equipment for a hospital electrocardiogram, which usually requires a monitoring device on a cart and a skein of connections, to an unobtrusive, wireless sensor that peels on and off like a Band-Aid. They also developed a wearable digital thermometer that is so sensitive it can sense minute changes in metabolism by measuring variations in body heat.



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Nature Nanotechnology.

"Right now, people feel sick and they go to the hospital to get everything checked, but those tests are bulky and you can't take them home," said bioengineer Yonggang Huang at Northwestern University who collaborates with Dr. Rogers. "We want to make these devices as flexible and soft as human skin so they can be put on the skin and worn like a child's tattoo."

This month, Dr. Huang and his colleagues reported in Science that they had assembled off-the-shelf commercial components into a wireless stick-on digital skin patch that could monitor heart and brain activity as effectively as bulkier hospital equipment. They connected their microcircuits with tiny wires that fold and unfold in accordionlike pleats so the electronic patch could buckle, twist and flex without breaking.

2

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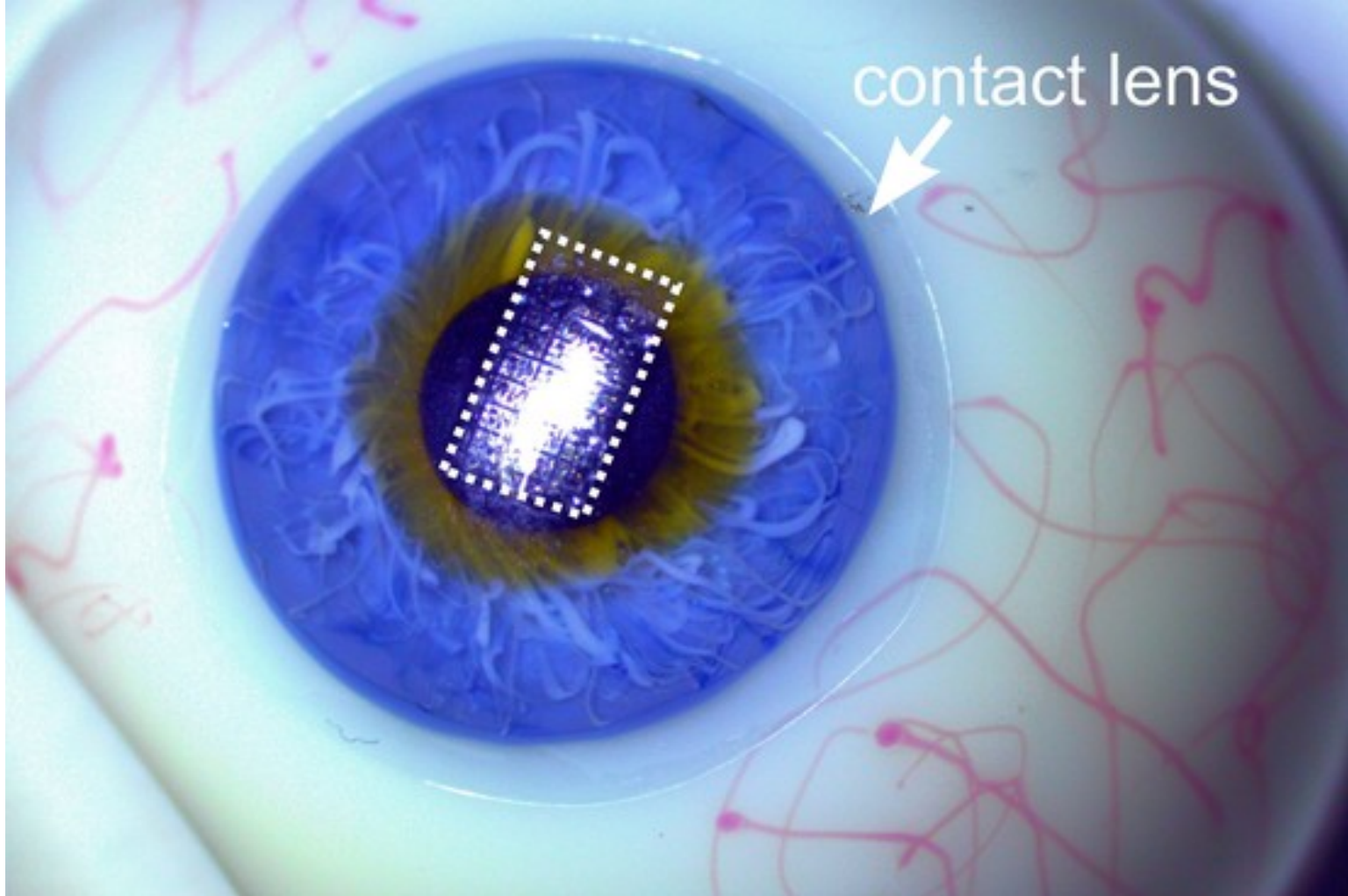


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A smart contact lens from the Swiss Federal Institute of Technology could monitor glaucoma. *Swiss Federal Institute of Technology*

At the Swiss Federal Institute of Technology in Zurich, electrical engineer Giovanni Salvatore and his colleagues are fabricating even thinner complex circuits so elastic that they can be wrapped around a strand of human hair without cracking or short-circuiting.

His research group is building transparent circuits on a membrane of a polymer plastic called parylene that is 1-micron thick. As a pilot project, they built a see-through strain gauge to monitor the buildup of pressure in the eye and mounted it on a contact lens. They also are developing a digital tattoo that can monitor heart rate and transmit the data wirelessly to a cellphone.

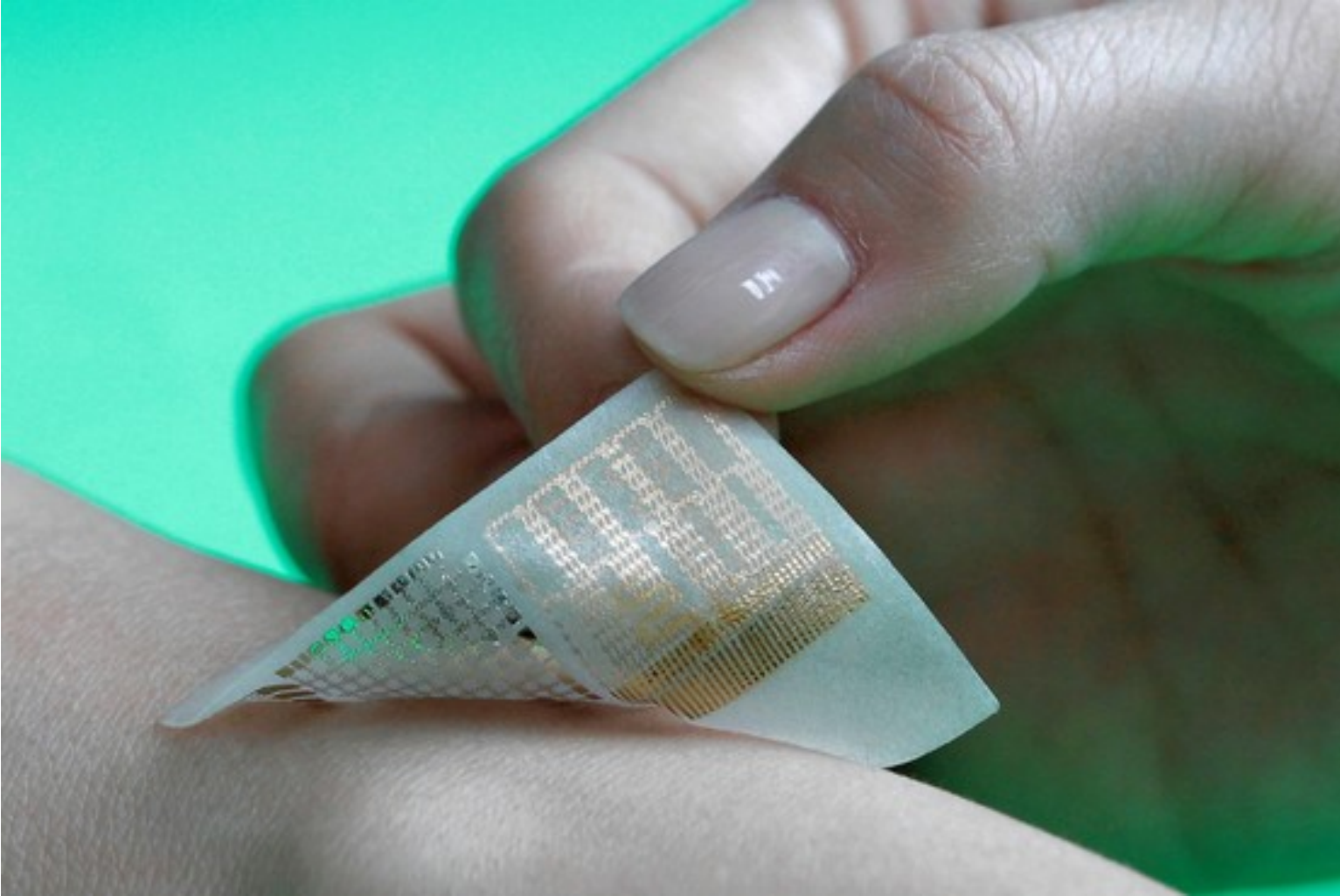
"The focus of the research is to make these ultra-flexible electronics that can be mounted on the skin or the body," said Dr. Salvatore.

And unlike conventional electronics that are built to last indefinitely, some of these experimental devices are biodegradable. Indeed, researchers are testing some medical diagnostic devices that can be programmed to vanish on schedule, completely and harmlessly dissolving in water or body fluids after days, months, or years.

"There are a lot of devices that you would like to implant in the body that don't need to function forever—a process for wound-healing, the healing of a bone, or the treatment of a cancerous tumor," said Dr. Rogers. "You would like to have some programmable electronic device but you would only need it for weeks or months."

To make vanishing medical implants, the researchers crafted electronic circuits from cocoon silk, thin sheets of porous silicon and magnesium electrodes—materials all capable of resorbing into the body. The materials aren't toxic and the quantities are smaller than those in the average vitamin supplement, the scientists said.

Add water and the circuits simply melt.



A smart bandage by researchers at Seoul National University can record muscle activity and trigger the release of a drug. *Donghee Son/Jongha Lee*

They use the silk to enclose and waterproof the circuit. They program the device to dissolve on schedule by varying the strength of the bonds between the silk molecules and by the thickness of the circuit itself. "We make these micro-Ziploc [bags], so you have to melt the Ziploc [bag] and then the device," said Dr. Omenetto at Tufts.

They tested the device as a biomedical implant in mice, using it to deliver a bactericide drug to surgical wound sites in the animals. The implant vanished on schedule, leaving only a faint residue of silk. That too was harmlessly absorbed into the body, they said.

"The idea is to make the electronics disappear by themselves when you no longer need it," Dr. Huang said. "All this technology has been demonstrated successfully on animal models. To really apply this to humans may be a long process."

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CELL ORGANELLES, STRUCTURES + FUNCTIONS

CELL MEMBRANE

location: on the outside of an animal cell and inside the cell wall of a plant cell

function: boundary that provides limited support to the cell and controls movement of materials in and out of the cell

CELL WALL

location: on the outside of a PLANT CELL

function: gives support and shape to cell

CHLOROPLASTS

location: distributed throughout the cytoplasm of a PLANT CELL

function: makes food by photosynthesis

CYTOPLASM

location: jellylike material throughout a cell

function: cellular liquid in which organelles are suspended

ENDOPLASMIC RETICULUM (ER)

location: distributed throughout the cytoplasm of a cell

function: makes lipids (fats) and packages proteins for delivery out of the cell

GOLGI COMPLEX (body/apparatus)

location: distributed throughout cytoplasm of a cell

function: changes, packages, and transports materials out of the cell

LYSOSOMES

location: distributed throughout cytoplasm of an ANIMAL CELL

function: digests food particles, waste, and foreign invaders (viruses, bacteria ...)

MITOCHONDRIA

location: distributed throughout cytoplasm of a cell

function: breaks down food molecules and releases energy

NUCLEUS

location: near the center of a cell

function: controls cell activities

RIBOSOMES

location: on ER and throughout the cytoplasm of a cell

function: make proteins

VACUOLE

location: distributed throughout the cytoplasm of a PLANT CELL

function: stores water and other substances

CHAPTER 1

Historical Aspects of Spleen and Splenic Surgeries

Andy Petroianu*

Department of Surgery of the Federal University of Minas Gerais, Belo Horizonte, Brazil

"Advance our standards; Inspire us with the spleen of fiery dragons! Victory sits on our helms."

William Shakespeare - King Richard III, act 5, scene 3.

Abstract: Since Antiquity, the spleen has been fascinating due to the mysteries of its existence and, to date, this is the organ about which we know the least. The most ancient documentation of the spleen comes from the Chinese. Throughout history, many functions have been attributed to the spleen. For a more didactic presentation, this chapter will be divided into three larger topics, in which the historical aspects of the spleen – Morphology, Physiology and Surgery – will be treated. Great advances in splenic morphology are due to Marcelo Malpighi. His outstanding studies on the spleen, around 1686, resulted in the knowledge of the splenic capsule and its intraparenchymatous insertions, in a trabecular form. The first study on the vascular pedicle of the spleen is attributed to Julius Caesar Arantius, in 1571. The greatest importance attributed to the spleen is the protection of the organism against infections. Hua T'o, had performed a full splenectomy in the second century a.D. in China. The first splenectomy described in detail was carried out by Adrian Zaccarelli, in 1549. The first partial splenectomy may have been performed in 1581. In 1590, Dr. Viard used a string to stitch a segment of the spleen that had come become exposed due to a small abdominal wound and performed the first partial splenectomy. The first description of the splenic implant in the peritoneum, after a human trauma, was reported by H. Albrecht (1896), in Germany. In 1985, Salky *et al.*, considered that the decapsulation of the non-parasitic splenic cyst by laparoscopy was the definitive treatment for this disturbance. The authors of the first total splenectomy executed by laparoscopy most likely belong to Delaitre and Maignien (1991). Only with persistent study can the spleen cease to be, in the words of Galen (second century), "an organ full of mysteries", "*mysterii pleni organon*".

Key Words: Spleen, History, Surgery, Pathophysiology, Morphology, Physiology, Complications, Anatomy.

INTRODUCTION [1-9]

Since Antiquity, the spleen has been fascinating due to the mysteries of its existence and, to date, this is the organ about which we know the least. On the other hand, even without a reasonable explanation for our current comprehension, many peoples throughout the ages have attributed functions to the spleen, which, centuries later, science could prove to be true. It is quite amazing how the ancient philosophers, with no resources other than that of observation, described the spleen quite accurately, in both morphological and functional aspects.

The most ancient documentation of the spleen comes from the Chinese. In traditional Chinese Medicine, the spleen is one of the four organs of the body and is related to the defence of the organism, the supply of energy from other organs and digestion. In fact, the spleen performs all of these functions, and since it represents 25% to 30% of the phagocyte mononuclear system, it is responsible for the removal of antigens from circulation. The splenic macrophages phagocyte bacteria, viruses and fungi, even without the presence of opsonins. This organ produces lymphocytes, all of the immunoglobulins, as well as the diverse peptides that are important within the organism immune system defences. The energy described by the Ancient Chinese can be represented by the red blood cells that the spleen releases into the circulation of many mammals in situations which require a greater systemic effort. As regards the role of the spleen in digestion, two aspects should be considered. First, the spleen is the precursor of a great majority of hepatocyte functions, such as the formation of bilirubins, and takes part in the formation cycles of peptides and lipids. The second aspect is of microscopic digestion, which is exercised by splenic macrophages.

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Andy Petroianu (Ed)

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Record: 1

Title: Serum and red blood cell folate testing for folate deficiency: new features?

Authors: De Bruyn, Edward¹
Gulbis, Béatrice¹
Cotton, Frédéric¹

Source: European Journal of Haematology. Apr2014, Vol. 92 Issue 4, p354-359. 6p.

Document Type: Article

Subject Terms: *FOLIC acid deficiency
*ERYTHROCYTES
*VITAMIN B12
*HOMOCYSTEINE
*BLOOD plasma

Author-Supplied Keywords: anaemia
folate
folate deficiency
homocysteine
RBC indices
vitamin B12

NAICS/Industry Codes: 414510 Pharmaceuticals and pharmacy supplies merchant wholesalers

Abstract: Introduction Folate deficiency is assessed by serum and red blood cell folate measurements. Nevertheless, no consensus for the lower limit of serum folate reference values exists. We investigated the appropriate use of RBC folate to detect folate deficiency and the relationship between serum and RBC folate and with other parameters such as vitamin B12 and homocysteine in order to propose serum folate cut-off values. Methods Retrospectively, 63 113 and 20 459 results of serum and RBC folate were collected. If present, the results of red cell indices, vitamin B12 and homocysteine were also collected. Results A significantly positive correlation between serum and RBC folate was demonstrated. A significant effect of serum folate levels under 6 µg/ L (or 14 n m) was observed on RBC indices. A relation was found between vitamin B12 and folate, for serum and RBC. A significant rise in homocysteine concentrations was observed for serum folate levels under 8 µg/ L (or 18 n m). Conclusion To observe haematological abnormalities, folate deficiency should be profound. Serum folate levels under 8 µg/ L (or 18 n m) should be considered as a decision limit for folate depletion because a positive effect on homocysteine was observed. Fasting serum folate concentration should be preferred for assessing folate status. Our results suggest that the need for RBC folate testing is less meaningful. [ABSTRACT FROM

AUTHOR]

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Aboo B.S.Fatally ABNS1405011

1. The term abdominal is an adjective for abdomen. In the axial plane the abdomen is superior to the pelvis.
2. The term acromial is an adjective for Acromium. It is a bony projection. It is part of the scapula. In the coronal plane It is lateral to the dorsal vertebrae.
- 3.



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Fatally**

Student Nurse



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< Chapter 5 Figure 5-1



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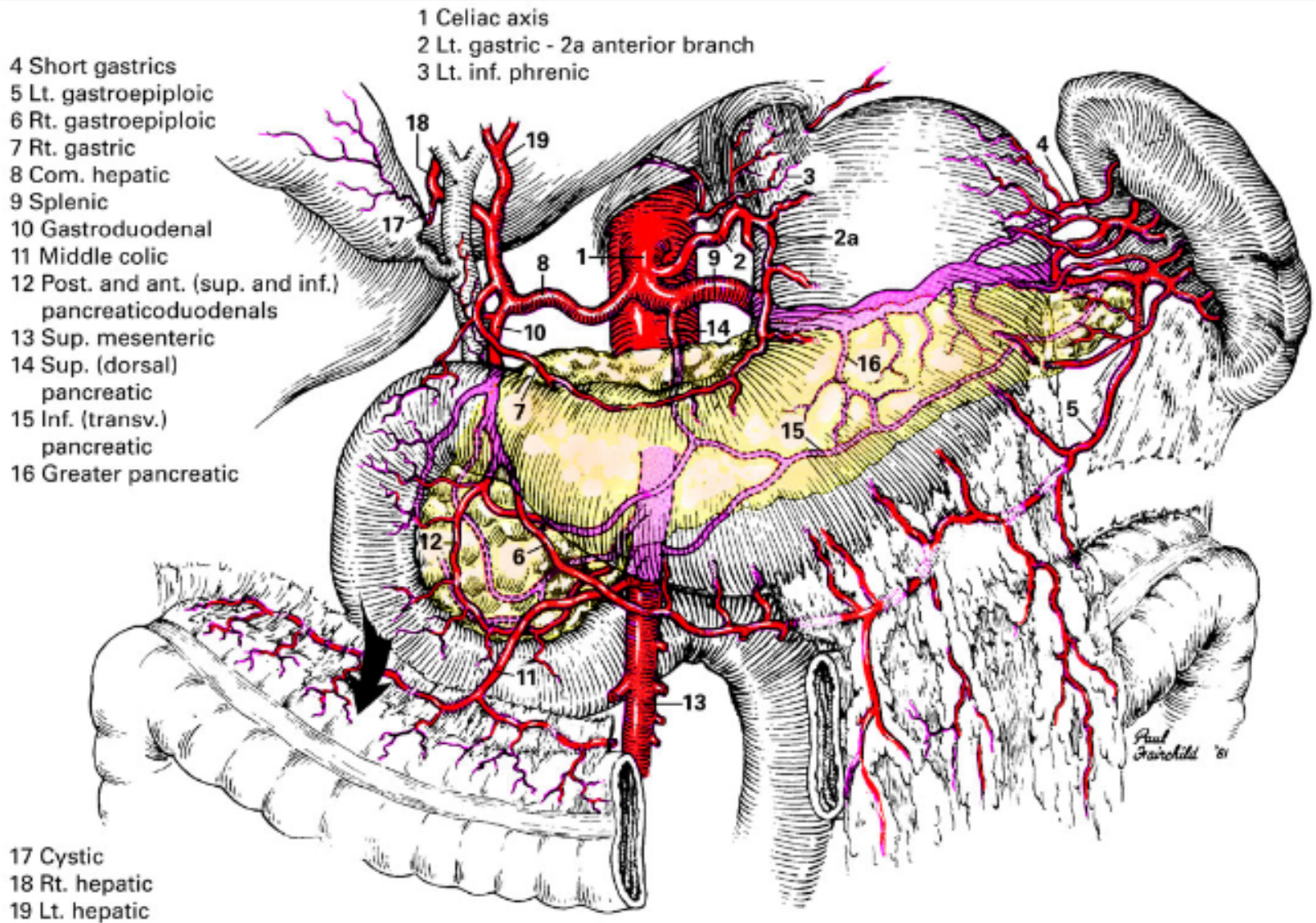
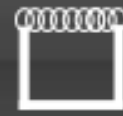


Figure 5-1

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$$\text{Transport}(T) = \text{Transport}(T) \quad \text{--- (1)}$$

$$\text{Cell to Membrane}(C_m) + \text{Transport} = \text{Cell membrane}(C_m) + \text{Transport } T$$

So

$$C_m + T = C_m + T \quad \text{--- (2)}$$

$$C_m + T + \text{Extracellular fluid}(E_f) = C_m + T + \text{Intracellular fluid}(I_f)$$

So

$$C_m + T + E_f = C_m + T + I_f \quad \text{--- (3)}$$

$$C_m + T + \{E_f = (\text{Plasma}(P) + \text{Interstitial fluid}(I_f))\} = C_m + T + \{I_f = (\text{Plasma}(P) + \text{Interstitial fluid}(I_f))\}$$

So

$$C_m + T + P + I_f = C_m + T + P + I_f$$

$$C_m + T + P + I_f + \{ \text{Intracellular fluid}(I_f) \} = C_m + T + P + I_f + I_f$$

$$= \{ \text{Plasma} + \text{Capillary} + I_f \} + C_m \{ I_f \} \quad ?$$

$$\begin{aligned} \text{Intracellular fluid}(I_f) + \text{Extracellular fluid}(I_f) &= \text{Intracellular fluid}(I_f) + \text{Extracellular}(I_f) \\ I_f + I_f &= I_f + I_f \\ &= C_m(I_f + I_f) \end{aligned}$$

$$\text{If } I_f(P + I_f) \neq I_f \text{ then } I_f(P + I_f + C_p + I_f) + C_m(I_f) = \text{--- (4)}$$

$$I_f(P + C_p + I_f) + C_m(I_f) \text{ or } I_f(P + C_p + I_f) + C_m + I_f = ?$$

Semester 4

①

Xerox 1

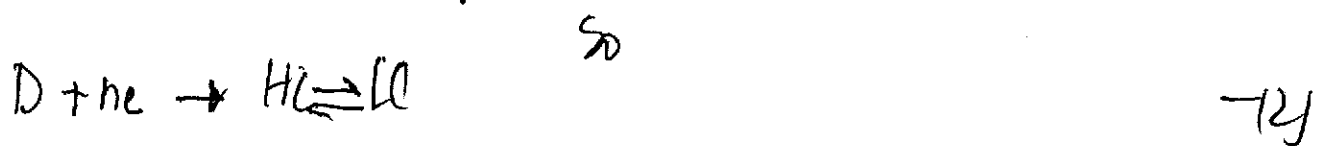
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$$Ext \left\{ \underbrace{(p_w + c_p + l_{sf})}_{BL} + c_m \{ l_{nf} \} \right\} = Ext \left\{ \underbrace{p + c_p + l_{sf}}_{12L} + c_m \underbrace{\{ l_{nf} \}}_{25L} \right\} \quad (5)$$

Biologic membrane (B_m) are composed of a phospholipid bilayer (PB) containing peripheral prot- (PP) and integral prot (IP).

$$B_m \left\{ PB + \{ PP + IP \} \right\} = B_m \left\{ PB + \{ PP + IP \} \right\} \quad (1)$$

{ Diffusion (D) of non-electrolyte (ne) takes place from higher conc (H) to lower conc L }



The rate of diffusion (RD) across a membrane (m) is a linear function (Lf) of the concentration diffn (CD).

The rate of diffusion (RD) across a membrane (m) is a linear function (Lf) of the concentration difference (CD).

$$RD + m + Lf + CD = RD + m + Lf + CD$$

$$\text{Psychology} + \text{Dentology}^{(D)} = \text{Dentology}^{(D)} + \text{Psychology}$$

$$\text{Dentology}^{(D)} = \text{Dentology}^{(D)}$$

$$\text{So } (OB = (D))$$

$$\text{Dentology}^{(D)} + \text{Duty}^{(DT)} + \text{Obligation}^{(OB)} = \text{Dentology}^{(D)} + \text{Duty}^{(DT)} + \text{Obligation}^{(OB)} \quad \text{--- (1)}$$

$$(D) + (DT) + (OB) = (D) + (DT) + (OB) \quad \text{--- (2)}$$

$$\text{Propriety}^{(P)} = \text{Propriety}^{(P)} \quad \text{--- (1)}$$

$$(P) + 5 \text{ stages} = (P) + 5 \text{ stages} \quad \text{--- (11)}$$

$$(P) + (\text{Adventure Beginner})^{(AB)} + \text{Expert}^{(E)} + \text{Novice}^{(N)} +$$

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$$\text{Cell (C)} + \text{Endoplasmic Reticulum (ER)} = \text{C} + \text{ER} + \dots \quad \text{--- (1)}$$

$$\text{C} + \text{ER} + \text{Golgi body (GB)} = \text{C} + \text{ER} + \text{Golgi body (GB)} \quad \text{--- (2)}$$

$$\text{C} + \text{ER} + \text{GB} + \text{Cell membrane (cm)} = \text{C} + \text{ER} + \text{GB} + \text{Cell membrane (cm)} \quad \text{--- (3)}$$

$$\text{C} + \text{ER} + \text{GB} + \text{cm} + \text{Nucleus (N)} = \text{C} + \text{ER} + \text{GB} + \text{cm} + \text{Nucleus (N)} \quad \text{--- (4)}$$

$$\text{C} + \text{ER} + \text{GB} + (\text{cm} + \text{N} + \text{Cytoplasm (Cy)}) = \text{C} + \text{ER} + \text{GB} + \text{cm} + \text{N} + \text{Cytoplasm (Cy)}$$

$$\text{C} + \text{ER} + \text{GB} + \text{cm} + \text{N} + \text{Cy} = \text{C} + \text{ER} + \text{GB} + \text{cm} + \text{N} + \text{Cy} \quad \text{--- (5)}$$

$$\text{C} + \text{ER} + \text{GB} + \text{cm} + \text{N} + \text{Cy} + \text{Nuclear membrane (Nm)} =$$

$$\text{C} + \text{ER} + \text{GB} + \text{cm} + \text{N} + \text{Cy} + \text{Nm (memb)}$$

$$\text{C} + \text{ER} + (\text{GB} + (\text{cm} + \text{N}) + \text{Cy}) + \text{Nm} = \text{C} + \text{ER} + \text{GB} + \text{cm} + \text{N} + \text{Cy} + \text{Nm} \quad \text{--- (6)}$$

1	2	3	4	5	6	7	8	9	10	11	12
JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9
10	10	10	10	10	10	10	10	10	10	10	10
11	11	11	11	11	11	11	11	11	11	11	11
12	12	12	12	12	12	12	12	12	12	12	12
13	13	13	13	13	13	13	13	13	13	13	13
14	14	14	14	14	14	14	14	14	14	14	14
15	15	15	15	15	15	15	15	15	15	15	15
16	16	16	16	16	16	16	16	16	16	16	16
17	17	17	17	17	17	17	17	17	17	17	17
18	18	18	18	18	18	18	18	18	18	18	18
19	19	19	19	19	19	19	19	19	19	19	19
20	20	20	20	20	20	20	20	20	20	20	20
21	21	21	21	21	21	21	21	21	21	21	21
22	22	22	22	22	22	22	22	22	22	22	22
23	23	23	23	23	23	23	23	23	23	23	23
24	24	24	24	24	24	24	24	24	24	24	24
25	25	25	25	25	25	25	25	25	25	25	25
26	26	26	26	26	26	26	26	26	26	26	26
27	27	27	27	27	27	27	27	27	27	27	27
28	28	28	28	28	28	28	28	28	28	28	28
29	29	29	29	29	29	29	29	29	29	29	29
30	30	30	30	30	30	30	30	30	30	30	30
31	31	31	31	31	31	31	31	31	31	31	31

Clinical placement
Clinical Instructor 1
Cory H. Hoffer

Florida Department of Health
Bureau of Health Services

NURSIO

ABSF

0205

2014

$$\text{Cell (C)} + \text{Endoplasmic Reticulum (ER)} = \text{C} + \text{ER} + \dots \quad \text{--- (1)}$$

$$\text{C} + \text{ER} + \text{Golgi body (GB)} = \text{C} + \text{ER} + \text{Golgi body (GB)} \quad \text{--- (2)}$$

$$\text{C} + \text{ER} + \text{GB} + \text{Cell membrane (Cm)} = \text{C} + \text{ER} + \text{GB} + \text{Cell membrane (Cm)} \quad \text{--- (3)}$$

$$\text{C} + \text{ER} + \text{GB} + \text{Cm} + \text{Nucleus (N)} = \text{C} + \text{ER} + \text{GB} + \text{Cm} + \text{Nucleus (N)} \quad \text{--- (4)}$$

$$\text{C} + \text{ER} + \text{GB} + (\text{Cm} + \text{N} + \text{Cytoplasm (Cy)}) = \text{C} + \text{ER} + \text{GB} + (\text{Cm} + \text{N} + \text{Cytoplasm (Cy)})$$

So

$$\text{C} + \text{ER} + \text{GB} + \text{Cm} + \text{N} + \text{Cy} = \text{C} + \text{ER} + \text{GB} + \text{Cm} + \text{N} + \text{Cy} \quad \text{--- (5)}$$

$$\text{C} + \text{ER} + \text{GB} + \text{Cm} + \text{N} + \text{Cy} + \text{Nuclear membrane (Nm)}$$

$$\text{C} + \text{ER} + \text{GB} + \text{Cm} + \text{N} + \text{Cy} + \text{Nm (memb)}$$

$$\text{C} + \text{ER} + \text{GB} + (\text{Cm} + \text{N} + \text{Cy}) + \text{Nm} = \text{C} + \text{ER} + \text{GB} + \text{Cm} + \text{N} + \text{Cy} + \text{Nm} \quad \text{--- (6)}$$

FChadec@aprobmannellaway-selbst.com

Clinical Instructor /
Clinical placement
Coordinator.

1 JANUARY	2 FEBRUARY	3 MARCH	4 APRIL	5 MAY	6 JUNE
SMTWTFS	SMTWTFS	SMTWTFS	SMTWTFS	SMTWTFS	SMTWTFS
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
6 7 8 9 10 11 12	6 7 8 9 10 11 12	6 7 8 9 10 11 12	6 7 8 9 10 11 12	6 7 8 9 10 11 12	6 7 8 9 10 11 12
13 14 15 16 17 18 19	13 14 15 16 17 18 19	13 14 15 16 17 18 19	13 14 15 16 17 18 19	13 14 15 16 17 18 19	13 14 15 16 17 18 19
20 21 22 23 24 25 26	20 21 22 23 24 25 26	20 21 22 23 24 25 26	20 21 22 23 24 25 26	20 21 22 23 24 25 26	20 21 22 23 24 25 26
27 28 29 30 31	27 28 29 30 31	27 28 29 30 31	27 28 29 30 31	27 28 29 30 31	27 28 29 30 31
7 JULY	8 AUGUST	9 SEPTEMBER	10 OCTOBER	11 NOVEMBER	12 DECEMBER
SMTWTFS	SMTWTFS	SMTWTFS	SMTWTFS	SMTWTFS	SMTWTFS
1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5 6 7

D.O.B. 18.06.52 STUDENT IDENTITY CARD TERTIARY Tariff

Fatally Aboo Bakar Sidick
Port Louis



APOLLO BRAMWELL NURSING SCHOOL
Apollo Bramwell Hospital MOKA
SIC No. : ABNS/14/011
Date of Expiry: APRIL 2015
School Term : 15 April 2014 - 19 Dec 2014
05 Jan 2015 - 14 April 2015



Issued by : National Transport Authority

Any of several kinds of colorless or nearly colorless cells of the immune system that circulate in the blood and lymph. Leukocytes comprises granulocytes and agranulocytes. Neutrophils, 55% to 70% of all leukocytes, are the most numerous phagocytic cells and are a primary effector cell in inflammation.

Eosinophils, 1% to 3% of total leukocytes, destroy parasites and are involved in allergic reactions.

Basophils, less than 1% of all leukocytes, contain granules of histamine and heparin and are part of the inflammatory response to injury. Monocytes,

3% to 8% of all leukocytes (have several functions: recognizing) becomes macrophages and phagocytize pathogens and damaged cells, esp. in the tissue fluid. Lymphocytes, 20% to 30% of all leukocytes have several functions: recognizing foreign antigens, producing antibodies, suppressing the immune response to prevent excess tissue damage, and becoming memory cells. Leukocytes are formed from the undifferentiated stem cells that give rise to all blood cells. Those in the bone marrow may become any of the five kinds of leukocytes. Those in the spleen

or SC/ GCE O-Level or equivalent with at least 2 credits including English and 5 years working experience.

The final decision to accept a student rests solely with the institution.

2.2 Admission Process

There are two phases to the admission process:

- Stage I : Preliminary Admission Test
- Stage II: Panel Interview

The interview aims to assess the candidate's suitability for the course, his/her motivation for taking the course and personal aspirations.

- Unconditional Offer

The offer becomes unconditional upon presentation of the following documents:

- 1) Birth Certificate
- 2) Identity Card
- 3) Medical Certificate, from a registered doctor, attesting to the mental and physical suitability of the candidate for the course. The results of the following laboratory exams should be made available to the medical doctor: urine and stool exams, complete blood count (CBC) and chest xray.
- 4) Certificate of vaccination against diphtheria, tetanus, poliomyelitis, hepatitis B, as well as a negative tuberculosis test. If the latter is positive, the certificate should clearly state that two unsuccessful attempts at vaccination by B.C.G. have been effected.
 - *The candidate needs to undergo the vaccination process as from the date of application. Proof of vaccination is to be shown on registration day / first day of the course.*
- 5) Certificate of morality.
- 6) Marriage Certificate, if applicable

- C. The threat, or possession of weapons, firearms, explosives, fireworks, or ammunition.
- D. The theft or unauthorized use/possession of school, hospital, or another person's property.
- E. Unauthorized use of ID cards for entry to school or hospital facilities.
- F. Tampering with or disabling emergency equipment.
- G. Making a false report, or failure, to comply with the directions of school/hospital employees acting within the scope of their assigned duties or position.
- H. Use, possession, or distribution of any controlled substance, unless legally prescribed by a physician. Use, possession, or distribution of alcoholic beverages on the hospital premises.

4. Certificate of Morality

You are subject to produce Certificate of Morality and your criminal record status must meet the requirements for entry to and continuation on a nursing programme. You must report (to your senior nurse educator) any situations you become involved with which leads to the involvement of the police or criminal proceedings, or call into question your good character or which might undermine the reputation of the profession, school or public safety or confidence.

In certain circumstances, your progression on the programme may be suspended until situations relating to any areas highlighted above have been resolved.

As a student nurse you are subject to Enhanced Disclosure procedures. It is important that all individuals who will work with the public at times when they are particularly vulnerable are scrutinized in terms of any criminal record to ensure that any risk to the public is minimized and public protection is enhanced.

Clinical Element

- The hours of clinical contact per week will vary per academic year as below:
 - No. of hours per day: 8 - 12 hrs
 - No. of days of duty per week: 3 - 5 days
 - Total hours of clinical field experience per week: between 40 - 45 hrs

The distribution of hours per week below is a guide as this will vary from year to year depending upon the number of hours allocated for theory and clinical/field experience.

<u>Year</u>	<u>Weeks</u>	<u>Weeks x Hours x days per Week</u>	<u>Weeks x hours x days per week</u>
		<u>Theoretical Element (theory+lab)</u>	<u>Clinical Element</u>
<u>First</u>	<u>45</u>	<u>31 x 6.5 x 5 ~ 1000 hrs</u>	<u>11 x 8 x 5 +10 ~ 450 hrs</u>
<u>Second</u>	<u>45</u>	<u>41 x 6 x 3 ~ 740 hrs</u>	<u>43 x 8 x 2.5 ~ 810 hrs</u>
<u>Third</u>	<u>45</u>	<u>23 x 6 x 4 ~ 545 hrs</u>	<u>27 x 8 x 5 ~ 1080 hrs</u>
<u>TOTAL</u>	<u>135</u>	<u>Total hrs = 2285</u>	<u>Total hrs = 2340</u>
<u>Total Hours for the Programme = 4625</u>			

Standards

- The Diploma programme will be based on a modular CREDIT SYSTEM.
 - 15 hours of lectures will be equivalent to 1 credit.
 - 45 hours of laboratory practice will be equivalent to 1 credit
 - 90 hours of clinical placement will be equivalent to 1 credit.
- Proficiency in theory and clinical practice will be assessed by tutors/mentors/linked tutor after each semester/year and

NURS 2003	Psychosocial Context of Health and Illness II	30/45	3
NURS 2004	Medical and Surgical Nursing I	90/45	7
NURS 2005	Obstetric and Midwifery I	75/45	6
NURS 2006	Community Health Nursing II	15/20	1.5
NURS 2007	An Introduction to Research	20/50	2.5
NURS 2008	Nursing Management and Education II	30/45	3
NURS 2009	Specialized Nursing 1	60/45	5
NURS 2000	Clinical Placement II	810 Hrs	9
	Total	380 L, 360 P, 810 CP	42.5
YEAR 3			
NURS 3001	Research in Nursing	15/0	1
NURS 3002	Nursing Management and Education III	30/20	2.5
NURS 3003	Obstetric and Midwifery II	40/60	4
NURS 3004	Medical and Surgical Nursing II	40/80	4.5
NURS 3005	Specialized Nursing 1I	80/120	8
NURS 3006	Professional Project in Nursing	15/45	2
NURS 3000	Clinical Placement III	1080 Hrs	12
	Total	220 L, 325 P, 1080 CP	34
	GRAND TOTAL		130

7. Description of Modules

NURS 1001 - NURSING THEORY AND PRACTICE I

Introduction to Nursing; Supervised Clinical Observation; Nursing Science; Nursing care of the Patient / Client. Basic Nursing Care and Needs of the Patient.

First Aid: Introduction; Importance of first aid and rules of first aid; Concept of emergency. First Aid in Emergency situations. Community Emergencies and Resource Community Emergencies.

Personal Hygiene: Introduction: Concept of health and its relation to successful living. Maintenance of Health. Physical Health.

Nutrition: Introduction; Classification of food. Normal dietary requirements and deficiency diseases of each of the constituents of food. Preparation, Preservation and Storage of Food. Introduction to Diet Therapy. Community Nutrition. Common Preparations / Practicals.

NURS 1002 - LIFE SCIENCES FOR NURSING

Introduction to anatomical terms. Organization of body cells, tissues, organs, systems membranes and glands. Skeletal System. Muscular System. Cardiovascular System, Lymphatic System. Respiratory System. Digestive System. Urinary System. Nervous System. Endocrine System. Sense Organs. Reproductive System.

Microbiology: Introduction; Brief historical review of bacteriology and microbiology; Scope and usefulness of knowledge of microbiology in nursing. Micro-organisms. Infection and its transmission. Immunity. The control and destruction of micro-organisms. Introduction to Laboratory techniques.

NURS 1003 - PSYCHOSOCIAL CONTEXT OF HEALTH AND ILLNESS I

Psychology: Introduction; Definitions, scope of psychology and its importance in nursing profession. Psychology of Human Behaviours. Learning. Observation. Intelligence. Personality. Communication.

NURS 1004 - PHARMACOLOGY

Concept of pharmacology. Classification of drugs. Administration of drugs. General action of drugs.

NURS 1005 - MENTAL HEALTH NURSING

Introduction: Meaning of mental health and mental illness. History of Psychiatry. Mental Health Assessment. Community Mental Health. Psychiatric Nursing Management. Mental disorders and Nursing Interventions: Functional Mental disorders; Definition, etiology, signs, symptoms, medical and nursing management. Bio-Psychosocial Therapies: Psychopharmacology; Psychosocial therapies; Somatic therapy. Forensic Psychiatry/Legal Aspects. Psychiatric Emergencies and Crisis Intervention.

NURS 1006 - COMMUNITY HEALTH NURSING I

Introduction to Community Health and Community Health Nursing. Community Health Nursing Process.

Environmental Hygiene: Introduction. Environmental Factors Contributing to Health Water. Community Organization to Promote Environmental Health. Health care services in Mauritius. Health Planning in Mauritius.

Health Assessment. Principles of Epidemiology and Epidemiological Methods. Family Health Nursing Care. Family Health Care Settings. Referral Systems. Records and Reports. Minor Ailments.

NURS 1007 - COMMUNICATION SKILLS & INFORMATION TECHNOLOGY

Writing of report using appropriate English Language: Grammar/Vocabulary.

NURS 1008 - NURSING MANAGEMENT AND EDUCATION I

Professional Trends and Adjustments - Introduction to nursing as a profession. Professional ethics. Personal and professional growth/development: a) Continuing Education; b) Career in Nursing. Legislation in Nursing. Professional and related organizations.

NURS 2001 - NURSING THEORY AND PRACTICE II

Assessment of Patient/Client: Principles and importance of assessment, methods of assessment: observation, palpation, auscultation, percussion, developing skill in observation. Therapeutic Nursing Care and Procedures Asepsis. Basic Needs and Care in Special Conditions.

NURS 2002 - PHARMACOTHERAPY FOR NURSING

Nursing implications in administration of drugs.

NURS 2003 - PSYCHOSOCIAL CONTEXT OF HEALTH AND ILLNESS II

Sociology: Introduction. The Individual. The Family. The Society. The Community. Economy.

NURS 2004 - MEDICAL AND SURGICAL NURSING I

Introduction. Nursing Assessment. Patho-Physiological Mechanism of Disease. Altered Immune Response. Clinical Pharmacology. Nurse's role in Management of Fluid, Electrolyte and Acid Base Balance. Management of Patients in Pain. Operation Theatre Technique Physical Environment: Preparation of theater equipment & supplies. Management of Patient Undergoing Surgery: Nursing management of pre-operative patient; Intra Operative Management; Post-operative management - Immediate and Routine. Nursing Management of Patient with Impaired Respiratory Function and Gaseous Exchange. Nursing Management of Patients with Digestive and Gastro Intestinal Disorders. Nursing Management of Patients with Metabolic and Endocrine Disorders. Emergency Management, Nurse's role in emergency conditions. Medical surgical emergencies.

NURS 2005 - MIDWIFERY & OBSTETRICS I

History and broad perspective of obstetrics. Review of Anatomy and Physiology of female reproductive system. Embryology. Pregnancy. Normal Labour. Normal Puerperium. Neo Natal Disorders.

NURS 2006 - COMMUNITY HEALTH NURSING II

Specialized community health services and nurse's role. Nurse's role in National Health Programmes. Demography and Family Welfare Demography. Health Team: Concept, Composition, Functions. Role of nursing personnel at various levels. Vital Health Statistics.

NURS 2007 - AN INTRODUCTION TO RESEARCH

Introduction to research process. Introduction to research approaches for nursing.

NURS 2008 - NURSING MANAGEMENT AND EDUCATION II

Administration and Ward Management - Introduction. Planning: Aims, Principle, Methods and Types. Organization: Command, Co-ordination and Control, Delegation. Staffing and Budgeting.

NURS 2009 - SPECIALISED NURSING I

AIDS (Acquired Immunodeficiency Syndrome) - Review the anatomy and physiology of the lymphatic and immune system. The pathogenesis of the HIVirus and its effect on health. Modes of transmission: Prevention Strategies at International, National and individual level. The epidemiology of HIV/AIDS and factors fuelling the epidemic. Opportunistic infection and Antiretroviral treatment. HIV Counselling and Testing. Psychosocial aspect of HIV/AIDS, Stigma and Discrimination. Standard Precautions and HIV Post Exposure Prophylaxis. Legal and Ethical issues in HIV.

Paediatric Nursing - Introduction: Concept in child health care; Trends in paediatric nursing; Role of paediatric nurse in child care. The Newborn. The Healthy Child. The Sick Child. Behavioural Disorders and common Health Problems. Children with congenital Defects/Malformations. Children with various disorders and diseases. Welfare of Children.

DIABETES MELLITUS - Type 1 and type 2 diabetes; key educational issues associated with each therapeutic agent; important educational areas in teaching self glucose monitoring and demonstration of a glucose measurement method; identification, treatment and prevention of hypoglycemia and hyperglycemia; essential components of a diabetes care plan and billing methods for nursing care of patients with diabetes; proper technique for drawing and injecting insulin; regulations-based whole blood technology testing and screening procedure; nutritional recommendations of the Diabetes Association; importance of patient education issues related to diabetes and

- 7) Academic Qualifications
- 8) 2 passport size photographs taken not more than 3 months beforehand
- 9) 2 reference letters

3. Program Duration

Minimum 3 years and maximum 5 years full-time.

4. Minimum Credits for Award of Diploma:

A minimum of 130 unit credits is required before the diploma is awarded.

5. Mode of Delivery

As nursing programmes require both a theoretical and practical elements, based upon the recommendations of the Nursing Council of Mauritius, it has been mutually agreed that theoretical classroom /laboratory teaching will represent around 50% of the course and the practical experience via clinical placements in hospitals and community health centres will be around 50%.

Theoretical Element

- The hours of contact per week will vary per academic year as below and include instruction and skills laboratory experience.
 - No. of hours per day: between 6 - 7 hrs
 - No. of days of instruction per week: 3 - 5 days.
 - Total hours of instruction per week: between 30 and 35 hrs
- Each module comprises of lectures, tutorials, group work, practical (if applicable) and self-directed studies.
- Teaching will take place at school, in laboratories, in clinical areas and in the community.

Introduction to Nursing:

- Supervised Clinical Observation
- Nursing Science
- Nursing Care of the Patient
- Basic Nursing Care and Needs of the patient

First Aid:

- Introduction
- Importance of first aid and rules of first aid
- Concept of emergency
- First Aid in Emergency situations
- Community Emergencies and Resources
- Community Emergencies

Personal Hygiene:

- Introduction
- Concept of Health and its relation to successful living
- Maintenance of Health
- Physical Health

Nutrition:

- Introduction
- Classification of food
- Normal dietary requirements and deficiency diseases of the constituents of food
- Preparation, Preservation and Storage of Food
- Introduction to Diet Therapy
- Community Nutrition
- Common Preparations and Practicals

Microbiology

- Introduction
- Brief historical review of bacteriology and microbiology
- Scope and Usefulness of knowledge of microbiology in Nursing
- Microorganism
- Infection and its transmission
- Immunity
- The Control and destruction of microorganisms
- Introduction to Laboratory techniques

Introduction to anatomical terms

- Organization of body cells,tissues,organs,systems,membranes and glands
- Skeletal systems
- Cardiovascular system
- Muscular system
- Lymphatic system
- Respiratory System
- Digestive System
- Urinary System
- Nervous System
- Endocrine System
- Sense Organs
- Reproductive System

Psychology:

- Introduction
- Definitions, Scope of Psychology and its importance in nursing profession
- Psychology of human behaviours
- Learning
- Observation
- Intelligence
- Personality
- Communication

Communication Skills and Information Technology

Writing of Report using appropriate English Language: Grammar/Vocabulary

Professional Trends and Adjustments

-Introduction to Nursing as a profession

-Professional Ethics

Personal and Professional growth/development

a. Continuing Education

b. Career in Nursing

-Legislation in Nursing

-Professional and related Organization

performance kept on a cumulative basis up to the final year of study.

General Conditions

- For the award of the Diploma, a student needs to pass in all modules, including the project work, clinical placement assessment, theoretical aspects and has to earn 130 credits.
- The final assessment will be based on the performance of the student throughout the 3 years of study on both theoretical and practical aspects (70% for continuous assessment and 30% for final assessment).

6. Programme Plan – Diploma in General Nursing

YEAR 1			
CODE	MODULE NAME	Hours L/P	CREDITS
NURS 1001	Nursing Theory and Practice I	150/ 135	13
NURS 1002	Life Sciences for Nursing	75/ 135	8
NURS 1003	Psychosocial Context of Health and Illness I	75/ 0	5
NURS 1004	Pharmacology	75/ 20	5.5
NURS 1005	Mental Health Nursing	75/0	5
NURS 1006	Community Health Nursing I	75/90	7
NURS 1007	Communication Skills	20/10	1.5
NURS 1008	Nursing Management and Education I	45/20	3.5
NURS 1000	Clinical Placement I	450 Hrs	5
	Total	590 L, 410 P, 450 CP	53.5
YEAR 2			
NURS 2001	Nursing Theory and Practice II	30/45	3
NURS 2002	Pharmacotherapy for Nursing	30/20	2.5

6. Programme Plan – Diploma in General Nursing

YEAR 1			
CODE	MODULE NAME	Hours L/P	CREDITS
NURS 1001	Nursing Theory and Practice I	150/ 135	13
NURS 1002	Life Sciences for Nursing	75/ 135	8
NURS 1003	Psychosocial Context of Health and Illness I	75/ 0	5
NURS 1004	Pharmacology	75/ 20	5.5
NURS 1005	Mental Health Nursing	75/0	5
NURS 1006	Community Health Nursing I	75/90	7
NURS 1007	Communication Skills	20/10	1.5
NURS 1008	Nursing Management and Education I	45/20	3.5
NURS 1000	Clinical Placement I	450 Hrs	5
	Total	590 L, 410 P, 450 CP	53.5
YEAR 2			
NURS 2001	Nursing Theory and Practice II	30/45	3
NURS 2002	Pharmacotherapy for Nursing	30/20	2.5



01 April 2014

Mr. Aboo Bakar Sidick FATALLY
P.O.Box 1153
Port Louis Centre
Port Louis

Dear Mr. Fatally,

Re: Selected for Admission on the Diploma in General Nursing

I am pleased to inform you that you have been selected for admission on the Diploma in General Nursing with Apollo Bramwell Nursing School (ABNS) for the April 2014 intake.

In order to confirm your seat, you need to sign the *acceptance of the offer* and the *student contract* with Apollo Bramwell Nursing School by the 9th of April 2014. For more information, please call Mrs. Karuna Beekoo or Ms. Zareen Mowla on 6051080.

Congratulations and we look forward to welcoming you as a student of ABNS.

Yours Sincerely,

Mae Florence D. Nierras (Mrs.)

Vice President - Academic



APOLLO BRAMWELL NURSING SCHOOL

c/o Apollo Bramwell Hospital, Moka, Mauritius - T: (230) 605 1080 - F: (230) 433 3350
E: info@apollobramwellnursingschool.com - W: www.apollobramwellnursingschool.com

BRC No.: C08074963



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Congratulations and we look forward to welcoming you as a student of ABNS.

Yours Sincerely,

Mae Florence D. Nierras (Mrs.)
Vice President - Academic



INDUCTION PROGRAM FOR BATCH V

April 9 - 11, 2014

Wednesday - 09 April

- | | | |
|---------|---|--------|
| 9:00 am | Administrative Initiatives | Zareen |
| | <ul style="list-style-type: none"> Giving out of letter of acceptance from ABNS Signing of letter of acceptance by the student Signing of Contract & Confidentiality and Disclosure Agreement Payment of Registration and Tuition Fees Enrolment procedures Bus pass arrangements Uniform arrangements | |

12:00 Lunch Break

- | | | |
|---------|---|-------------------------------------|
| 1:00 pm | Welcome | Valerie |
| | <ul style="list-style-type: none"> Brief History of ABNS Introduction of ABNS staff An Overview of the DGN Program Student Services | Valerie
Mae
Mae
Zareen/Mae |

Thursday - 10 April

- | | | |
|-------|-------------------------------------|---------|
| 9:00 | What is your Learning Style? | Chottoo |
| | Time Management | Chottoo |
| 12:00 | Lunch break | |
| 1:00 | How to Succeed in a Nursing Course | Felzal |
| 2:00 | Challenges in a Diverse Environment | Mo |
| 3:00 | Tour of Apollo Bramwell Hospital | Cls |

Friday - 11 April

- | | | |
|-------|---|------------|
| 9:00 | ABNS Expectations of its Students | |
| | <ul style="list-style-type: none"> Corporate Policies School Policies | Doy
Mae |
| | Getting to Know You | |
| 12:00 | Lunch | |



APOLLO BRAMWELL NURSING SCHOOL
ORIENTATION PROGRAM -ADMINISTRATIVE
BATCH 5

WEDNESDAY 9 APRIL 2014

Start Time : 09.00am

- Sign Attendance Sheet
- Signature of ADMISSION ACCEPTANCE FORM by student
- Signature of 2 copies STUDENT CONTRACT (initial on all pages)
- Signature of CONFIDENTIALITY & DISCLOSURE AGREEMENT
- Payment of Registration and Tuition Fees
- Enrollment procedures – Fill enrollment form
- Module registration form
- Signature of list for BUS PASS and payment for Bus Pass
- Meeting with Bramer Bank Representative for Educational Loan
- Signature of Attendance Sheet

Break/ Lunch time:

- 10:15 – 10:30

Learning Styles Questionnaire

by Honey & Mumford

This questionnaire is designed to find out your preferred learning style. Over the years you have probably developed learning habits which help you benefit more from some experiences than others. Since you are probably unaware of this, this questionnaire will help you pinpoint your learning preferences, so that you are in a better position to select learning experiences to suit your style.

There is no time limit to this questionnaire. It will probably take 10-15 minutes. The accuracy of the results depend on how honest you can be. There are no right or wrong answers. If you agree more than you disagree with a statement, put a tick by it. If you disagree more than you agree put a cross. Be sure to mark each item either with a tick or a cross.

- | | | |
|--------------------------|----|---|
| ☐ | 1 | I like to be absolutely correct about things. |
| ☐ | 2 | I quite like to take risks. |
| ☐ | 3 | I prefer to solve problems using a step by step approach rather than guessing. |
| ☐ | 4 | I prefer simple, straightforward things rather than something complicated. |
| ☐ | 5 | I often do things just because I feel like it rather than thinking about it first. |
| ☐ | 6 | I don't often take things for granted. I like to check things out for myself. |
| ☐ | 7 | What matters most about what you learn is whether it works in practice. |
| ☐ | 8 | I actively seek out new things to do. |
| ☐ | 9 | When I hear about a new idea I immediately start working out how I can try it out. |
| ☐ | 10 | I am quite keen on sticking to fixed routines, keeping to timetables, etc. |
| ☐ | 11 | I take great care in working things out. I don't like jumping to conclusions. |
| ☐ | 12 | I like to make decisions very carefully and preferably after weighing up all the other possibilities first. |
| ☐ | 13 | I don't like 'loose ends', I prefer to see things fit into some sort of pattern. |
| ☐ | 14 | In discussions I like to get straight to the point. |
| ☐ | 15 | I like the challenge of trying something new and different. |
| ☐ | 16 | I prefer to think things through before coming to a conclusion. |
| ☐ | 17 | I find it difficult to come up with wild ideas off the top of my head. |
| ☐ | 18 | I prefer to have as many bits of information about a subject as possible, the more I have to sift through the better. |
| ☐ | 19 | I prefer to jump in and do things as they come along rather than plan things out in advance. |
| ☐ | 20 | I tend to judge other people's ideas on how they work in practice. |

- ☐ 21 I don't think that you can make a decision just because something feels right. You have to think about all the facts.
- ☐ 22 I am rather fussy about how I do things - a bit of a perfectionist.
- ☐ 23 In discussions I usually pitch in with lots of ideas.
- ☐ 24 In discussions I put forward ideas that I know will work.
- ☐ 25 I prefer to look at problems from as many different angles as I can before starting on them.
- ☐ 26 Usually I talk more than I listen.
- ☐ 27 Quite often I can work out more practical ways of doing things.
- ☐ 28 I believe that careful logical thinking is the key to getting things done.
- ☐ 29 If I have to write a formal letter I prefer to try out several rough workings before writing out the final version.
- ☐ 30 I like to consider all the alternatives before making my mind up.
- ☐ 31 I don't like wild ideas. They are not very practical.
- ☐ 32 It is best to look before you leap.
- ☐ 33 I usually do more listening than talking.
- ☐ 34 It doesn't matter how you do something, as long as it works.
- ☐ 35 I can't be bothered with rules and plans, they take all the fun out of things.
- ☐ 36 I'm usually the 'life and soul' of the party.
- ☐ 37 I do whatever I need to do, to get the job done.
- ☐ 38 I like to find out how things work.
- ☐ 39 I like meetings or discussion to follow a proper pattern and to keep to a timetable.
- ☐ 40 I don't mind in the least if things get a bit out of hand.

Scoring

For each question you ticked on the other sheets, put a '1' beside the question number on this sheet. Put nothing for crosses. Add up the 1s in each column.

1	4	2	11
3	7	5	12
6	9	8	16
10	14	15	18
13	20	19	21
17	24	23	25
22	27	26	29
28	31	35	30
38	34	36	32
39	37	40	33

Theorist

Pragmatist

Activist

Reflector

2014 Year Planner – Batch 5

2014	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T
January			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
February						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
March						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
April		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
May				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
June							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
July		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
August					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
September	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
October			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
November						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
December	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23

TIMETABLE FOR APRIL 2014 - BATCH 5

Week 2

[illegible]

Week 3

Apr - Monday 14th		Apr - Tuesday - 15th		Apr - Wednesday 16th		Apr - Thursday 17th		Apr - Friday 18th	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:30 - 4:00
Nurs1001	Nurs 1007	Nurs1001	Nurs 1003	Nurs1001	Nurs 1008	Nurs 1002	Nurs 1003	Nurs 1002	Nurs 1008
BD Gunes	C Aubdool	BD Gunes	C Aubdool	BD Gunes	CJ Seegolam	BM Degorio	C Aubdool	BM Degorio	CJ Seegolam
				MFD Nierras					Mentorship Course

Week 4

[illegible]

Week 5

Apr - Monday 28th		Apr - Tuesday - 29th		Apr - Wednesday 30th		May- Thursday 1st		May - Friday 2nd	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30			8:00 - 12:00	1:30 - 3:30
Nurs1001	Nurs 1007	Nurs1001	Nurs 1003	Nurs1001	Nurs 1008	LABOR DAY Bank Holiday		Nurs 1002	Nurs 1008
C Aubdool	C Aubdool	A Nathoo	C Aubdool	A Nathoo	CJ Seegolam			BM Degorio	CJ Seegolam
									Mentorship Course

From: **Aboo.B.S.Fatally** aboo.b.s.fatally@live.com

Subject: Re: Batch 5

Date: April 10, 2014 at 9:49 PM

To: aboo b s fatally aboo.b.s.fatally@live.com

Cc: gavinsoodin@yahoo.com, niraudwarika@gmail.com, sanjeena1303@hotmail.com, vitisha.kurrooman@gmail.com, msoophul@yahoo.com, ashshaha21@hotmail.co.uk, mephishacoo@myt.mu, lisaauckbur@live.com, booms73@live.com, ppargass@yahoo.com, maeel@hotmail.com, micro_eyes_11@yahoo.com, mungurkevin@yahoo.com, keshelvi1519@gmail.com, luqonly@hotmail.com, juliestarla@hotmail.com, shikshafokeer@hotmail.com, hanaa.solim@live.com, shameembeekhory@hotmail.co.uk, wondersumy@live.com, silavente_julia@yahoo.com, yudishsuharye19@gmail.com, amirosekandpal@yahoo.com, ashna14ramgoolam@gmail.com, chrislallbeeharry@gmail.com

Fellow Students

I am pleased to send you this list which network our group.

Thanks

Good luck

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Moderator

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Hana solim
Shameem Biko
Sumaiyah Dinmahamed
ange et demon
yudish Suharye
Muskaan Sharif
Ashna Ramgoolam
Chris Lallbeeharry

Nadine ✓
shiksha ✓
Hanaa ✓
Shameem ✓
Sumaiyah ✓
Julia ✓
Yudish ✓
Khodabux Amirah ✓
Ramgoolam Vijayaluxmi ✓
Chris Inshduth Lallbeeharry ✓

Amiira h

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- Kev dylan

- Kevin Padaruth

Please, note down your email address as well as your facebook I.D so as it can help us to create a group so as to facilitate our lectures and to be able to share information.

Name:

email:

Facebook I.D

- | | | |
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Ashna Ramgoolam

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**APOLLO BRAMWELL
NURSING SCHOOL**

STUDENT HANDBOOK



Chapter I Vision and Mission Statements

1. Vision

The Apollo Bramwell Nursing School shall be the best nursing school in Mauritius and the region and shall become internationally recognized as a Center of Excellence in Nursing Education.

Program development will be geared towards research and evidence-based practice and forging strong academic exchanges with international universities of repute.

2. Mission

Our mission is to strive to provide the highest level of nursing instruction and develop parallel courses for a holistic approach to nursing education in order to produce highly qualified and specialized nursing officers of the highest standards who can become tomorrow's leaders in the field of nursing and research.

3. Philosophy

The philosophy of Apollo Bramwell Nursing School is embodied in the following statements:

Human beings are unique, rational individuals possessing self-worth and dignity, deserving recognition of essential qualities: intellectual, psychological, physical, spiritual and social. Human beings can utilize their potential for self-development and self-improvement. People are capable of modifying their environment and their responses to it.

The **Environment** covers all influences the individual's internal responses, beliefs, values and experiences. Environment includes influences of culture,

family, religion and community. Diversity of environment and the individual is respected at all times. Health care professionals should recognize the growing diversity of society and the need to provide culturally sensitive care. Health care professionals must also recognize their role to assess and analyze a client's situation in order to relate a variety of contexts ranging from individual patient encounters to the management of complex systems.

Health is a dynamic state of wellness. Health practices must be geared towards prevention of illness and promotion of wellness with an emphasis on primary and secondary preventive strategies. Promoting a healthy lifestyle enhances health. It involves the active participation of patients, families, and communities in decisions regarding their health, and in evaluating its quality and accessibility. Health care professionals have a responsibility to participate as "community partners" and advocate public policy for promotion and protection of the health of society.

Nursing is a complex, interactive profession that is an art and a science. Nursing provides specific scientific, evidence based support and assistance to individuals and/or families, managing information and technology, while also assuming a personal code of ethics and social responsibility. Nurses must have up-to-date clinical skills and abilities as critical thinkers and problem solvers. As primary care givers, nurses must be prepared to function in new health care settings and with multiple interdisciplinary team members designed to provide optimally coordinated care. Today's nurse strives to insure cost-effective care balanced with appropriate care and quality of services and health outcomes.

Education is a process resulting in the learner's cumulative, progressive acquisition of knowledge, skills, competencies, values, attitudes and outcomes. It requires an environment of active, creative, and innovative participation between teacher and learner. Nursing education seeks to be proactive in anticipating changes in health care and in responding appropriately to such changes to enhance the preparation of the graduate nurse. Learning is a self-directed, life-long process, geared towards

developing and demonstrating relevant competencies throughout one's professional practice.

ABNS is responsible for integrating its philosophy into the academic program. The School's responsibility to the student focuses on facilitating effective adult learning by providing an appropriate learning environment that promotes the acquisition of knowledge, skills, competencies, values, attitudes, and outcomes essential to the development of the professional entry-level nurse.

Teaching as scholarship encompasses both the mastery of knowledge as well as the presentation of information so that others might understand it. ABNS in the diploma program is encouraged to explore innovation in adult learning and demonstrate creativity in the delivery of the teaching-learning process.

4. Values

Our fundamental values are:

- 1) **Equal opportunity:** We support all communities by providing the same training for each student regardless of race, color or faith.
- 2) **Caring and trustworthiness:** We manage ourselves with integrity by being honest in our communication and conduct and by showing concern for the well-being of others.
- 3) **Respect for diversity:** We treat people with dignity regardless of who they are or what they believe in.
- 4) **Commitment to academic excellence:** We engage in our own learning and participate fully in the academic community's pursuit of knowledge.
- 5) **Team work** – We place a high premium on good working relationships amongst us as an essential key to accomplishing our goals.

5. Essential Competencies of the Graduate Nurse

The student will attain the following outcomes in knowledge, aptitude, skill, attitude, and values upon completion of the nursing program, and following successful entry as a professional nurse:

1. Demonstrate a specialized body of knowledge and skills essential for entry-level nursing practice in order to optimize client's health status in a diverse community and a variety of health care settings.
2. Recognize the implications of social-cultural, economic and political trends and their influences on the client's health status and the profession in order to carry out appropriate nursing responses.
3. Integrate critical thinking, effective communication, health teaching, and therapeutic nursing interventions, while implementing the nursing process.
4. Observe the Nursing Council of Mauritius Code of Ethics and project a positive image of the profession.
5. Demonstrate leadership and ability to collaborate with consumers and health care providers in a cost effective manner while providing care.
6. Acknowledge responsibility for personal and professional development through continuing education, lifelong learning and active community service.

6. Student Rights and Responsibilities

The following is a non-inclusive list of rights and responsibilities that each student shall be entitled to and abide by upon their enrollment in Apollo Bramwell Nursing School.

• **Academic Rights and Responsibilities**

1. The right to participate freely in class discussions, to offer opinions, and ask questions in regard to classroom presentations and clinical laboratory experiences. Students have the responsibility to become active rather than passive learners.

2. The right to the presence of a mentor in the clinical laboratory areas as the need arises; students have the responsibility to consult the mentor when questions or concerns arise.
3. The right to objective and fair evaluation of their theoretical and clinical laboratory performances. Grading systems will be carefully reviewed with students and faculty periodically for clarification and better student-faculty understanding.
4. The right to confidentiality in the student-instructor relationship; confidential information about the student will not be released without the knowledge or consent of the student, except in the case of potential danger to the student or another person.
5. The right to review their records subject to the published disclosure policies. Students are responsible for maintaining the accuracy of demographic information, such as address and name change.
6. It is a serious responsibility of students to be present in all timetabled classes, clinical placement rotation and meetings/activities organized by the academic staff, including counseling sessions and tutorials. Absence from these program activities will be met with appropriate sanction/penalty.
7. Students have the responsibility to treat all students, faculty and staff in a respectful manner and show consideration for other's views and opinions. Students have the responsibility to support other students' learning.

- **General Student's Rights and Responsibilities**

7. Students have the right to recognition and understanding of their individuality.
8. No student will be discriminated against on the basis of race, color, religion, age, sex marital status, national or ethnic origin, disability, or any other non-merit factor.
9. Students have the right to a responsible voice in the formulation of institutional policies affecting academic and student affairs. All reasonable actions will be taken to inform students of changes to policies, procedures, and costs prior to the actual effective change.

10. Students have the responsibility to abide by the rules, policies, and procedures of the school.
11. Disciplinary proceedings will be instituted for violation of policies and procedures published in the Student Handbook or as may be provided to the student during the academic year. It is the student's responsibility to be familiar with and abide by these rules and regulations.
12. Students have the right to appeal any decision they feel is unfair. It is the responsibility of the student to use the Grievance/Due Process procedures in the appropriate manner to redress any grievance.
13. Students have the right to a written copy of the rules, policies, and procedures that affect academic and student affairs, as well as written information regarding financial aid, school safety and security, and other consumer information issues.

Chapter II: Diploma in General Nursing

1. Aims and Objectives

Objectives

- To operate a School of Nursing where the students will acquire the necessary knowledge, skills and aptitudes to meet the requirements to function as Registered Nursing Officers in Mauritius and beyond.
- Establish, maintain and supply a pool of trained nurses to support the Apollo Bramwell Hospital, government hospitals and other private clinics in the region and beyond.
- Impart education and training in nursing and allied subjects for the diffusion of useful knowledge and skills relevant to the needs of the community and the country.

Aims

The overall aim of the educational programme is to prepare safe and competent practitioners, equipping them with the skills necessary to respond constructively to a changing health care environment, which means having a curriculum that:

- Fosters an enthusiasm for learning and develop skills which will enable students to identify their own learning needs, engage in personal and professional development and develop a commitment to lifelong learning.
- Develops in the student skills of enquiry, analysis and problem solving, which will result in professional, competent, reflective practitioners, able to integrate theory and research into practice.
- Engenders in students an insight into the needs of a wide range of client groups by facilitating students' understanding of a variety of perspective on health, ill-health and the educative, restorative and rehabilitative aspects of nursing practice.
- Is practice-led, research orientated and appropriate to addressing contemporary nursing issues in a variety of clinical settings.
- Enables students to develop effective practice in a multidisciplinary environment, promote inter-professional understanding, cooperation and communication for team working and contribute to maintaining and improving standard of care.
- Facilitates the preparation of practitioners who are fit to practice, purpose and award and enable registration with regulatory bodies to be licensed to practice.

2. Admission to the Program

2.1 General Entry Requirements

- HSC or GCE A-Level with 2 A levels or equivalent
or SC / GCE O-Level or equivalent with a pass in English and credit in 5 other subject including Science (Applicants having credit in English Language need to have credit in only 4 other subjects)
or SC / GCE O-Level or equivalent with at least 3 credits including English and at least 3 years relevant working experience together with any formal or informal learning/training supported by testimonials.

or SC/ GCE O-Level or equivalent with at least 2 credits including English and 5 years working experience.

The final decision to accept a student rests solely with the institution.

2.2 Admission Process

There are two phases to the admission process:

- Stage I : Preliminary Admission Test
- Stage II: Panel Interview

The interview aims to assess the candidate's suitability for the course, his/her motivation for taking the course and personal aspirations.

- Unconditional Offer

The offer becomes unconditional upon presentation of the following documents:

- 1) Birth Certificate
- 2) Identity Card
- 3) Medical Certificate, from a registered doctor, attesting to the mental and physical suitability of the candidate for the course. The results of the following laboratory exams should be made available to the medical doctor: urine and stool exams, complete blood count (CBC) and chest xray.
- 4) Certificate of vaccination against diphtheria, tetanus, poliomyelitis, hepatitis B, as well as a negative tuberculosis test. If the latter is positive, the certificate should clearly state that two unsuccessful attempts at vaccination by B.C.G. have been effected.
 - *The candidate needs to undergo the vaccination process as from the date of application. Proof of vaccination is to be shown on registration day / first day of the course.*
- 5) Certificate of morality.
- 6) Marriage Certificate, if applicable

- 7) Academic Qualifications
- 8) 2 passport size photographs taken not more than 3 months beforehand
- 9) 2 reference letters

3. Program Duration

Minimum 3 years and maximum 5 years full-time.

4. Minimum Credits for Award of Diploma:

A minimum of 130 unit credits is required before the diploma is awarded.

5. Mode of Delivery

As nursing programmes require both a theoretical and practical elements, based upon the recommendations of the Nursing Council of Mauritius, it has been mutually agreed that theoretical classroom /laboratory teaching will represent around 50% of the course and the practical experience via clinical placements in hospitals and community health centres will be around 50%.

Theoretical Element

- The hours of contact per week will vary per academic year as below and include instruction and skills laboratory experience.
 - No. of hours per day: between 6 - 7 hrs
 - No. of days of instruction per week: 3 - 5 days.
 - Total hours of instruction per week: between 30 and 35 hrs
- Each module comprises of lectures, tutorials, group work, practical (if applicable) and self-directed studies.
- Teaching will take place at school, in laboratories, in clinical areas and in the community.

Clinical Element

- The hours of clinical contact per week will vary per academic year as below:
 - No. of hours per day: 8 - 12 hrs
 - No. of days of duty per week: 3 - 5 days
 - Total hours of clinical field experience per week: between 40 - 45 hrs

The distribution of hours per week below is a guide as this will vary from year to year depending upon the number of hours allocated for theory and clinical/field experience.

<u>Year</u>	<u>Weeks</u>	<u>Weeks x Hours x days per Week</u>	<u>Weeks x hours x days per week</u>
		<u>Theoretical Element (theory+lab)</u>	<u>Clinical Element</u>
<u>First</u>	<u>45</u>	<u>31 x 6.5 x 5 ~ 1000 hrs</u>	<u>11 x 8 x 5 +10 ~ 450 hrs</u>
<u>Second</u>	<u>45</u>	<u>41 x 6 x 3 ~ 740 hrs</u>	<u>43 x 8 x 2.5 ~ 810 hrs</u>
<u>Third</u>	<u>45</u>	<u>23 x 6 x 4 ~ 545 hrs</u>	<u>27 x 8 x 5 ~ 1080 hrs</u>
<u>TOTAL</u>	<u>135</u>	<u>Total hrs = 2285</u>	<u>Total hrs = 2340</u>
<u>Total Hours for the Programme = 4625</u>			

Standards

- The Diploma programme will be based on a modular CREDIT SYSTEM.
 - 15 hours of lectures will be equivalent to 1 credit.
 - 45 hours of laboratory practice will be equivalent to 1 credit
 - 90 hours of clinical placement will be equivalent to 1 credit.
- Proficiency in theory and clinical practice will be assessed by tutors/mentors/linked tutor after each semester/year and

performance kept on a cumulative basis up to the final year of study.

General Conditions

- For the award of the Diploma, a student needs to pass in all modules, including the project work, clinical placement assessment, theoretical aspects and has to earn 130 credits.
- The final assessment will be based on the performance of the student throughout the 3 years of study on both theoretical and practical aspects (70% for continuous assessment and 30% for final assessment).

6. Programme Plan – Diploma in General Nursing

YEAR 1			
CODE	MODULE NAME	Hours L/P	CREDITS
NURS 1001	Nursing Theory and Practice I	150/ 135	13
NURS 1002	Life Sciences for Nursing	75/ 135	8
NURS 1003	Psychosocial Context of Health and Illness I	75/ 0	5
NURS 1004	Pharmacology	75/ 20	5.5
NURS 1005	Mental Health Nursing	75/0	5
NURS 1006	Community Health Nursing I	75/90	7
NURS 1007	Communication Skills	20/10	1.5
NURS 1008	Nursing Management and Education I	45/20	3.5
NURS 1000	Clinical Placement I	450 Hrs	5
	Total	590 L, 410 P, 450 CP	53.5
YEAR 2			
NURS 2001	Nursing Theory and Practice II	30/45	3
NURS 2002	Pharmacotherapy for Nursing	30/20	2.5

NURS 2003	Psychosocial Context of Health and Illness II	30/45	3
NURS 2004	Medical and Surgical Nursing I	90/45	7
NURS 2005	Obstetric and Midwifery I	75/45	6
NURS 2006	Community Health Nursing II	15/20	1.5
NURS 2007	An Introduction to Research	20/50	2.5
NURS 2008	Nursing Management and Education II	30/45	3
NURS 2009	Specialized Nursing 1	60/45	5
NURS 2000	Clinical Placement II	810 Hrs	9
	Total	380 L, 360 P, 810 CP	42.5
YEAR 3			
NURS 3001	Research in Nursing	15/0	1
NURS 3002	Nursing Management and Education III	30/20	2.5
NURS 3003	Obstetric and Midwifery II	40/60	4
NURS 3004	Medical and Surgical Nursing II	40/80	4.5
NURS 3005	Specialized Nursing 1I	80/120	8
NURS 3006	Professional Project in Nursing	15/45	2
NURS 3000	Clinical Placement III	1080 Hrs	12
	Total	220 L, 325 P, 1080 CP	34
	GRAND TOTAL		130

7. Description of Modules

NURS 1001 - NURSING THEORY AND PRACTICE I

Introduction to Nursing; Supervised Clinical Observation; Nursing Science; Nursing care of the Patient / Client. Basic Nursing Care and Needs of the Patient.

First Aid: Introduction; Importance of first aid and rules of first aid; Concept of emergency. First Aid in Emergency situations. Community Emergencies and Resource Community Emergencies.

Personal Hygiene: Introduction: Concept of health and its relation to successful living. Maintenance of Health. Physical Health.

Nutrition: Introduction; Classification of food. Normal dietary requirements and deficiency diseases of each of the constituents of food. Preparation, Preservation and Storage of Food. Introduction to Diet Therapy. Community Nutrition. Common Preparations / Practicals.

NURS 1002 - LIFE SCIENCES FOR NURSING

Introduction to anatomical terms. Organization of body cells, tissues, organs, systems membranes and glands. Skeletal System. Muscular System. Cardiovascular System, Lymphatic System. Respiratory System. Digestive System. Urinary System. Nervous System. Endocrine System. Sense Organs. Reproductive System.

Microbiology: Introduction; Brief historical review of bacteriology and microbiology; Scope and usefulness of knowledge of microbiology in nursing. Micro-organisms. Infection and its transmission. Immunity. The control and destruction of micro-organisms. Introduction to Laboratory techniques.

NURS 1003 - PSYCHOSOCIAL CONTEXT OF HEALTH AND ILLNESS I

Psychology: Introduction; Definitions, scope of psychology and its importance in nursing profession. Psychology of Human Behaviours. Learning. Observation. Intelligence. Personality. Communication.

NURS 1004 - PHARMACOLOGY

Concept of pharmacology. Classification of drugs. Administration of drugs. General action of drugs.

NURS 1005 - MENTAL HEALTH NURSING

Introduction: Meaning of mental health and mental illness. History of Psychiatry. Mental Health Assessment. Community Mental Health. Psychiatric Nursing Management. Mental disorders and Nursing Interventions: Functional Mental disorders; Definition, etiology, signs, symptoms, medical and nursing management. Bio-Psychosocial Therapies: Psychopharmacology; Psychosocial therapies; Somatic therapy. Forensic Psychiatry/Legal Aspects. Psychiatric Emergencies and Crisis Intervention.

NURS 1006 - COMMUNITY HEALTH NURSING I

Introduction to Community Health and Community Health Nursing. Community Health Nursing Process.

Environmental Hygiene: Introduction. Environmental Factors Contributing to Health Water. Community Organization to Promote Environmental Health. Health care services in Mauritius. Health Planning in Mauritius.

Health Assessment. Principles of Epidemiology and Epidemiological Methods. Family Health Nursing Care. Family Health Care Settings. Referral Systems. Records and Reports. Minor Ailments.

NURS 1007 - COMMUNICATION SKILLS & INFORMATION TECHNOLOGY

Writing of report using appropriate English Language: Grammar/Vocabulary.

NURS 1008 - NURSING MANAGEMENT AND EDUCATION I

Professional Trends and Adjustments - Introduction to nursing as a profession. Professional ethics. Personal and professional growth/development: a) Continuing Education; b) Career in Nursing. Legislation in Nursing. Professional and related organizations.

NURS 2001 - NURSING THEORY AND PRACTICE II

Assessment of Patient/Client: Principles and importance of assessment, methods of assessment: observation, palpation, auscultation, percussion, developing skill in observation. Therapeutic Nursing Care and Procedures Asepsis. Basic Needs and Care in Special Conditions.

NURS 2002 - PHARMACOTHERAPY FOR NURSING

Nursing implications in administration of drugs.

NURS 2003 - PSYCHOSOCIAL CONTEXT OF HEALTH AND ILLNESS II

Sociology: Introduction. The Individual. The Family. The Society. The Community. Economy.

NURS 2004 - MEDICAL AND SURGICAL NURSING I

Introduction. Nursing Assessment. Patho-Physiological Mechanism of Disease. Altered Immune Response. Clinical Pharmacology. Nurse's role in Management of Fluid, Electrolyte and Acid Base Balance. Management of Patients in Pain. Operation Theatre Technique Physical Environment: Preparation of theater equipment & supplies. Management of Patient Undergoing Surgery: Nursing management of pre-operative patient; Intra Operative Management; Post-operative management - Immediate and Routine. Nursing Management of Patient with Impaired Respiratory Function and Gaseous Exchange. Nursing Management of Patients with Digestive and Gastro Intestinal Disorders. Nursing Management of Patients with Metabolic and Endocrine Disorders. Emergency Management, Nurse's role in emergency conditions. Medical surgical emergencies.

NURS 2005 - MIDWIFERY & OBSTETRICS I

History and broad perspective of obstetrics. Review of Anatomy and Physiology of female reproductive system. Embryology. Pregnancy. Normal Labour. Normal Puerperium. Neo Natal Disorders.

NURS 2006 - COMMUNITY HEALTH NURSING II

Specialized community health services and nurse's role. Nurse's role in National Health Programmes. Demography and Family Welfare Demography. Health Team: Concept, Composition, Functions. Role of nursing personnel at various levels. Vital Health Statistics.

NURS 2007 - AN INTRODUCTION TO RESEARCH

Introduction to research process. Introduction to research approaches for nursing.

NURS 2008 - NURSING MANAGEMENT AND EDUCATION II

Administration and Ward Management - Introduction. Planning: Aims, Principle, Methods and Types. Organization: Command, Co-ordination and Control, Delegation. Staffing and Budgeting.

NURS 2009 - SPECIALISED NURSING I

AIDS (Acquired Immunodeficiency Syndrome) - Review the anatomy and physiology of the lymphatic and immune system. The pathogenesis of the HIVirus and its effect on health. Modes of transmission: Prevention Strategies at International, National and individual level. The epidemiology of HIV/AIDS and factors fuelling the epidemic. Opportunistic infection and Antiretroviral treatment. HIV Counselling and Testing. Psychosocial aspect of HIV/AIDS, Stigma and Discrimination. Standard Precautions and HIV Post Exposure Prophylaxis. Legal and Ethical issues in HIV.

Paediatric Nursing - Introduction: Concept in child health care; Trends in paediatric nursing; Role of paediatric nurse in child care. The Newborn. The Healthy Child. The Sick Child. Behavioural Disorders and common Health Problems. Children with congenital Defects/Malformations. Children with various disorders and diseases. Welfare of Children.

DIABETES MELLITUS - Type 1 and type 2 diabetes; key educational issues associated with each therapeutic agent; important educational areas in teaching self glucose monitoring and demonstration of a glucose measurement method; identification, treatment and prevention of hypoglycemia and hyperglycemia; essential components of a diabetes care plan and billing methods for nursing care of patients with diabetes; proper technique for drawing and injecting insulin; regulations-based whole blood technology testing and screening procedure; nutritional recommendations of the Diabetes Association; importance of patient education issues related to diabetes and

exercise, illness and hypoglycemia; emotional, social and financial barriers to adherence with diabetes.

NURS 3001 - RESEARCH IN NURSING

Research in nursing, link with professional project for future nurses.

NURS 3002 - NURSING MANAGEMENT AND EDUCATION III

Health Education/Teaching in Clinical Setting - Introduction. Methods and Medium of Health Education. Health Education Agencies.

NURS 3003 - MIDWIFERY & OBSTETRICS II

High risks pregnancy. Post Datism. Complications in Pregnancy. Induction of labour, Preterm labour and Post maturity: Abnormalities of Labour; Abnormalities of puerperium; Obstetrical emergencies and operative obstetrics; Special cases.

NURS 3004 - MEDICAL AND SURGICAL NURSING II

Nursing Management of Patients with Renal and Urinary Disorders. Nursing Management of Patients with Neurological Disorders. Nursing Management of Patients with Disorders of Connective Tissue and Collagen Disorders. Nursing Management of the Elderly.

NURS 3005 - SPECIALISED NURSING II

Ophthalmology - Assessment of function of eyes. Diseases and disorders of eyes and their management.

Otorhinolaryngology (Disorders of ear, nose, throat) - Assessment of the function of Ear, Nose and Throat. Disorders and diseases of the Ear, Nose and Throat. Disorders of nose, Paranasal Sinuses, Throat and adenoids. Surgery and Nursing care. Dietetics: Diet in ENT diseases.

Cardiology - Nursing Management of Patients with Cardio-Vascular Circulatory and Haematological Disorders. Assessment of cardio-vascular functions. Management of patients with cardio-vascular diseases. Sample and request for blood transfusion. Safety checks and records for blood transfusion.

Burns - Definition and types of burns. Causes of burns. First Aid measures. Management of a patient with Burns. Accident & Emergency dept. General and specific Nursing care.

Oncology - Introduction. Nursing management of patient receiving oncologic treatment.

Plastic/Reconstructive Surgery - Types. Nursing implications in preparing patient for plastic/ reconstructive surgery.

Nephrology - Review of Anatomy and Physiology of renal system: Medicine; Surgery; Renal Nursing.

NURS 3006 - PROFESSIONAL PROJECT IN NURSING

Definition of professional project in nursing. Personal training and counseling about the professional project.

8. Non-discrimination statement

Apollo Bramwell Nursing School does not discriminate on the basis of race, color, religion, age, sex, marital status, national or ethnic origin, or disability in the administration of its educational policies, scholarship or other school administered programs.

If individuals believe that they have been subjected to such discrimination, they should contact the CEO.

9. Educational Policy

When an applicant is admitted to the Apollo Bramwell Nursing School, he/she is subject to all policies and procedures of the school. Admission to the school **carries no assurance of promotion, graduation, or awarding of a diploma.** Continuation as a student, promotion, and eventual graduation are dependent on the fulfillment of all academic requirements and compliance with all policies and procedures of the school. Failure to comply with these requirements may result adverse consequences, up to and including dismissal. If the student is dismissed, no assurance is given that he/she will be readmitted.

10. Changes to Policies and Procedures

All policies, procedures, requirements, and costs shown in this handbook are subject to change without prior notification. Students should check both their individual e-mailboxes and the official bulletin boards regularly for the most accurate and up to date information. All reasonable actions will be taken to inform students of changes to policies, procedures, and costs prior to the actual effective change.

Chapter III: Academic Policies

The School's Academic Regulations apply to all educational provisions offered by the school which bears academic credit and detail procedures covering aspects of your experience such as student conduct, appeals, complaints and assessment.

1. Admissions, Promotions and Academic Standards (APAS) Committee

This school committee reviews reports of scholastic counseling, analyzes student progress, makes decisions regarding **admission, promotion, evaluation, graduation, and dismissal of students**. This committee also oversees the disciplinary process for academic and non-academic matters. As part of its deliberation or investigation, the APAS committee may request that an individual student appear before the committee. Students involved in adverse academic or non-academic situation may request a personal appearance before the committee.

2. Academic Load

All students shall carry the prescribed academic load for the term/year. This will include theory, laboratory and clinical placement.

3. Registration / Enrolment

(i) All students selected to attend courses at the School are required to register before starting their respective courses and at the beginning of each subsequent semester for the duration of the course enrolled.

(ii) Students are required to register in all modules offered in a semester, except in cases where an exemption from module/s has been approved by the Faculty Board. [The processing and approval of application for exemption from module will be subjected to the policy of the University of Mauritius in this regard.]

(iii) Except as with permission from the Vice President Academic a student may not enroll in units of study with a total value of more than 24 credit points in either semester one or two; or less than 3 credit points in the same period.

- (iv) Information on the venue, date and time of registration will be communicated officially to selected applicants.
- (v) The deadline for late registration/de-registration of modules shall be at the end of week seven (7) of the semester.
- (vi) At the time of registration, all students are required to sign a statement undertaking that they will conform to the rules and regulations in force at the School.
- (vii) At the time of registration, all registered students are issued with a Student Identity Card which must be carried at all times and produced on request. A student who loses his/her Identity Card must inform the A/A Coordinator immediately. A duplicate card may be issued on payment of a fee, which is subject to change subsequently.
- (viii) For the purpose of registration, students will have to produce: original certificates (Birth, Marriage, Academic qualification, Identity card, Morality, reference letters), two passport size photos, and pay the registration fee.
- (ix) All students are required to state, at the time of registration, their address and other particulars. Any change in name or address must be notified immediately in writing to the A/A Coordinator. This also applies to any subsequent change in the information s/he has provided at registration.
- (x) All fees for the academic year are payable at the time of registration unless arrangements have been made with the School President. Results of the examination will be withheld for non-payment of fees due.
- (xi) A student is not allowed to register for any academic year if s/he has fees in arrears due to the School for a previous academic year, except for special permission of the School President.
- (xii) Arrangements may be made for students with special needs.
- (xiii) All students must fill in the Student Feedback Questionnaire as from mid-semester. They will be given until the end of the module registration period for the following semester to fill in the Questionnaire. Until and unless the Questionnaire will have been filled in, students will not be allowed to register for the modules for the following semester in view of

completing registration formalities. (UoM, Ch 3[3.4.1 v])

4. Termination of Registration (Ch 2, Section 2.2 General Regulations for Students, University of Mauritius)

- (i) A person shall cease to be a registered student of the School:
 - (a) when s/he has completed the scheme of study for which s/he is registered; a student's registration will lapse at the end of the semester in which s/he has successfully completed the minimum requirements for the award of the degree, diploma or certificate.
 - (b) if s/he withdraws from the School;
 - (c) during the period of his/her interruption of studies;
 - (d) if under any of ABNS Regulations s/he is required to withdraw from the School;
 - (e) if her/his Cumulative Point Average (CPA) remains below 50 for two consecutive registered semesters, unless decided otherwise by the Senate UoM;
 - o Any student whose registration had been terminated under sections (d), (e) above or who had withdrawn from the University as from the 3rd week after the beginning of the first semester of year one without submitting valid reason(s) at the time of application for withdrawal should not be admitted on the same programme until a period of one year upon termination of registration.
 - o Students whose CPA is less than 50 for two consecutive registered semesters may be allowed, subject to approval by Board of Examiners, APAS and Senate, to continue with the programmes provided:
 - i. at least 75% of the number of credits required for the degree have already been earned; and
 - ii. the maximum allowable duration of the programme, as specified in the structure, has not been exceeded.

- Requests for extension from such students will not be entertained and periods of interruption of study will count towards the maximum allowable duration, as per existing rule.

(ii) The Faculty Board will terminate the registration of students who had abandoned their programme of study.

5. Attendance and Progression

(i) The Diploma in General Nursing programme stipulates 100% attendance. A student will be required to attend regularly lectures, tutorials and other forms of instruction prescribed by her/his scheme of study and to complete the required elements that make up the Continuous Assessment component of the programme. Attendance of practical sessions and submission of reports by their appointed date/s are compulsory.

(ii) When the hours lost by absence reaches 20% of the hours of lecture, laboratory or clinical placement in a semester, the student shall be summoned to appear before the Academic Board (APAS) and will be asked to show cause why s/he should not be deemed to have failed to complete that unit of study.

- The following situations may be considered as excused absence:
 - a. Illness of student with supporting evidence;
 - b. The student has met an accident;
 - c. Family crisis [death, impending death of an immediate family member];
 - d. The Government proclaims suspension of school activities in case of natural calamity.

In all situations, except (d), a letter of explanation signed/attested to by a parent or guardian must form part of supporting evidence.

All other reasons for being absent are considered unexcused.

(iii) The Senate of the University of Mauritius may, on the recommendation of the Faculty Board and APAS, suspend or preclude from further study any student whose attendance or

progress is deemed to be unsatisfactory. (Ch 2 Sec 2.3 General Regulations for Students, University of Mauritius)

- (iv) Absence due to ill health must immediately be notified by the student to the Vice President Academic [VPA] through the Academic & Administrative Coordinator [AAC]. Inability to attend classes for any reason must notify, in writing, the VPA through the AAC, and supply relevant documentation (i.e. medical/ or attendance certificate). The documentation must be made available to the AAC as soon as possible after the absence. Final approval rests with the VPA. It will be the responsibility of the student to make up for missed events and to complete the relevant requirements.
- (v) Students who are unable to attend classes/clinical placement and examinations for reason of pregnancy/child delivery/ child care or major health problems must apply for leave beforehand. Such applications must be supported by relevant documentation (medical certificate/s indicating the expected date of delivery or reason/s of urgency, etc.)
- (vi) A student is expected to be punctual in reporting to class or clinical placement. One who comes in fifteen (15) minutes late may not be allowed to enter the class or clinical area by the Nurse Educator / Clinical Instructor / Mentor concerned. S/he will be marked absent. And the absence will be considered unexcused.
- (vii) A student is advised against going on early leave whether during class or clinical placement. Should an urgent situation arise that will necessitate ones leaving the premises/campus before the allotted time, the student must secure the consent of his/her programme coordinator if he/she is in school or his/her mentor or a clinical instructor when in clinical placement. Time incurred during early leaves will be counted against the hours required either in lectures or in clinical placement.
- (viii) Students whose progress, attendance or conduct during the semester is not satisfactory shall be given a written warning by the VPA.

- (ix) In case there is still no improvement, the matter shall be referred to APAS who will hear all parties concerned and decide on the necessary course of action. The decision of the APAS will be final and binding.
- (x) Additional Policies in Clinical Placement
 - a. A student may have five days excused absence in one year without penalty or sanction. Should the absence go beyond five days, replacement of days missed will be required.
 - b. A student who is unable to report for duty on a scheduled shift should call the nurse-in-charge of the department/ward at least 3 hours before the time s/he is expected to report. Failure to do so would incur a sanction of four (4) days replacement for time lost.
 - c. A student is to report 15 minutes before official duty time.

Reporting late for duty three (3) times would be considered one day unexcused absence, which in turn will incur a sanction to replace lost time by four (4) days.
 - d. When on clinical placement the student shall remain within the hospital premises for the entire period of the shift and shall not go out without the consent of the mentor/or clinical instructor. Should there be a need to leave the work post before the official time for dismissal the student must inform the nurse-in-charge or a clinical instructor before leaving the premises. Willful violation of this policy will be considered unauthorized early leave, a major misdemeanor, which shall be raised to APAS for disciplinary action.
 - e. A student reporting for duty or leaving the hospital premises is required to sign in or sign out on two logbooks, one in the department where s/he is assigned and the other with the security.
 - f. All absences beyond what is allowed in (a) will need to be replaced. This includes time counted as sanction for unexcused absences. Make-up duty must be completed within the time frame set by the Clinical Coordinator. If for any reason a student is unable to report for make-up duty, the same procedure will apply as in (b) (c) (d) (e).

- g. The Clinical Instructor has the right to relocate or dismiss a student from the clinical area if, in his professional judgment, the student is not prepared for work, the student's physical or mental health prohibits provision of safe care or if the student exhibits unprofessional behaviour (i.e. conflict, insubordination).
- h. The nursing programme does not permit mitigation against a 'fail' in clinical practice. This is to ensure client safety. Nursing students experiencing difficulties which may affect their performance in clinical practice must withdraw themselves from placement and seek support from the clinical coordinator. Mitigation may be permitted for placement hours and completion of placement learning outcomes.
- i. A student is expected to abide by the policies set by the institution / agency allocated for his/her clinical placement. Any violation of policy will be dealt with on a case to case basis.

6. The Credit System.

- (i) The DGN programme is based on a modular credit system. The programme abides by the guidelines set by the University of Mauritius, its awarding body.
- (ii) All modules are assigned a unit value. One unit represents at least 15 contact hours of lecture/recitation; at least 45 hours of laboratory/skills lab practicum/workshops and 90 hours of clinical placement/duty.
- (iii) **Minimum Credits for Award of Diploma:**
A minimum of 130 unit credits is required before the diploma is awarded. A total of 4660 hours of theoretical and clinical training [2320 theory / 2340 clinical] comprise the whole programme.
- (iv) **Assessment**
 - a. Each semester module will be assessed singly over 100 marks. Assessment will be based on a written examination of 2 to 3-hour duration and on continuous assessment done during the semester.

- Written examinations for modules will be carried out at the end of the semester according to the School Calendar. A written examination will count for 30% for all modules except in Research in Nursing and Professional Project in Nursing.
 - Continuous assessment may be based on assignments, laboratory work, seminars or any other assessment parameters stipulated in the course syllabus and should include at least two (2) assignments/tests per semester per module. Continuous assessment will count for 70% for all modules except in Research in Nursing and Professional Project in Nursing which have separate criteria for assessment.
 - An overall total of 50% for combined continuous assessment and written examination components would be required to pass the module, other than those with separate criteria mentioned above, with minimum thresholds within the individual continuous assessment and written examination.
- b. The Clinical Placement modules found in each year level of the programme are assessed at the end of the academic year. Assessment in these modules are guided by a Clinical Assessment Framework [see annex 1].
 - c. For Quality Assurance purposes, the final written examinations at the end of the semester are moderated by an External Examiner, as recommended by the University of Mauritius.
 - d. Examination results shall be approved by the Faculty Board, then presented to APAS for recommendation to the Senate Examinations Sub Committee for approval through the Examinations Office (as stated in the revised procedure for processing examination results, as approved by Senate at its 544th (Ordinary) Meeting held on 07 November 2012.)

** Same procedure applies for processing of Continuous Assessment results, which is done simultaneously with that of Written Examinations.*

e. Late or Non- Submission of Continuous Assessment.

- Unless Special Consideration or an extension has been granted, students are required to submit all assessment for a module on the specified due date. Failure to do so will normally incur penalties.
- If an extension is either not sought, not granted or is granted but work is submitted after the extended due date, the late submission of assessment will result in academic penalty as follows:
 - * for work submitted after the deadline but up to seven (7) calendar days late, a penalty of 2 per cent per day of the maximum mark awardable for the assignment will apply;
 - * for work submitted after 13 calendar days and less than two weeks after the deadline, a penalty of 5 per cent per day of the maximum awardable mark for the assignment will apply;
 - * for work submitted more than two weeks after deadline will be awarded a zero mark.
- Students who fail to submit or take part in Continuous Assessment for medical or other special reasons shall normally be assessed before the written examination.
- A student who fails to submit/take part in a Continuous Assessment activity due to medical/financial/other reasons (may be in 1 or both components of the module) will be given a mark of N in the final grading. Removal of such N mark should be done prior to enrolment in the succeeding semester if the module is a prerequisite to one that is offered in the next semester. Otherwise, the student is given a 1 year period where the (N) grade may be removed.

- f. Special Consideration for illness, injury or misadventure
- Special Consideration is a process that affords equal opportunity to students who have experienced circumstances that adversely impact their ability to adequately complete an assessment task in a module. The procedure for applying for Special Consideration should be observed.
 - The faculty does not offer opportunities for re-assessment other than on the grounds of approved Special Consideration.
 - A student who has successfully requested Special Consideration may be allowed to sit an exam or submit required course work on an alternative date determined by the faculty. In normal circumstances, further sittings of end of semester examinations will be scheduled during the two weeks following the School's formal examination period. The student will be given at least three days notice of the timing of a test. Marks will be awarded at full value for re-assessment where Special Consideration is approved. Non-submission of work or non-attendance at exams by the agreed time will be considered a failure of the assessment item.
 - Where students are unable to complete a clinical placement due to illness, injury or misadventure and Special Consideration has been granted, they will be required to make up all the missed time.
- g. Attendance in formal or informal examinations.
- A student is expected to attend 100% of clinical placement activities and a minimum of 80% of timetabled activities for a unit of study, unless granted exemption by the APAS. The APAS may determine that a student fails a module because of inadequate attendance. Alternatively, at the

Academic Committee's discretion, it may set additional assessment items where attendance is lower than 80%.

Attendance will be monitored and may be used by the Board of Examiners while making recommendations to APAS / Senate Examinations Sub-Committee/Senate. (as amended in 30 January 2013 under Section 2.3 of the University Regulations, University of Mauritius)

- A student who attends less than 80% of the above will not be allowed to take part in the Written Examination nor will his/her assignments/portfolios be considered for assessment and will be considered as failed unless under exceptional circumstances.
 - A student is required to be in attendance at the correct time and place of any formal or informal examinations. Non-attendance on any grounds insufficient to claim Special Consideration will result in forfeiture of marks associated with the assessment and may result in a failing mark for the module.
 - A student who fails to sit for one or more examination paper/s, or to submit an assignment on the grounds of exceptional circumstances or illness, supported by medical certificate/s, may be given special examination/s in the paper concerned in the following semester.
 - In case of illness, a Medical Certificate must be submitted to the AAC at latest **two days after** the examination. The School reserves the right to have a candidate examined by a doctor appointed by the School. In all cases the School must be satisfied with the evidence submitted.
- h. Deferral of examination/assignments/research paper

- Deferral of an examination may be granted on the following grounds: ill-health or injury and other special grounds considered appropriate by the VPA;
 - A student who wishes to defer an examination in a module must apply in writing to the VPA, for special consideration, setting out the grounds on which deferral is sought and provide sufficient evidence;
 - A student who has valid grounds for consideration of deferral of the submission of a research paper/assignment may apply in writing to the VPA for an extension time to submit the assignment;
 - Request for extension should be made two weeks before the end of the semester or the prescribed date of submission.
- i. Referred/Failed Candidates
- Nursing students will be offered a reassessment opportunity for any theory module or component of a theory module where they have failed to achieve the minimum of 50%. Any reassessment will be capped at 50%.
 - A student with a final result of less than 50% in Continuous Assessment in modules other than Clinical Placement will be required to repeat the module when it is offered next.
 - A student with a result less than 50% in the Written Examination needs to take a resit examination, even if the total rating for the module is more than 50%. Not more than two resits for any referred module will be given.
 - A student who fails in the Written Examination will take his/her resit examination as soon as possible, given

procedural constraints. Should a second resit be needed the same shall be given a month after the first resit.

- o In case a candidate still fails after two resits, the matter will be referred to the Senate of the University of Mauritius by APAS for necessary action.
 - o The maximum number of modules that a candidate is allowed to be referred should not exceed one third (1/3) of the total number of modules offered in that semester.
 - o Students may be offered an opportunity to repeat the whole module (even where only a component of a module is failed) in the following academic year depending on funding arrangements and the requirement they can complete the programme within five years.
- (v) The School will be guided by the policy of the University of Mauritius in regard to restrictions in permitting a student to follow a module, retake a module/s and repeat/re-registration of students on the programme under extenuating circumstances.
- (vi) Academic Standing and Awards
- a. The ABNS abides by the stipulated policy of the University of Mauritius, its awarding body, in determining the academic standing of students.
 - b. The faculty will monitor students for satisfactory progress towards the completion of their program. In addition to the common triggers used to identify students not meeting academic progression requirements (as reflected in the progression requirements of each module), students must satisfy any requirements identified in the course resolutions as being critical to progression through the course (e.g. number of hours completed in clinical placement)

- c. The award classification will be based on the Cumulative Point Average (CPA) at the end of the Programme of Studies as follows:

Diploma with DISTINCTION	CPA ≥ 70
Diploma at PASS level	CPA $50 \leq x < 70$

7. Clinical Assessment Framework

Assessment is a critical element of the mentoring process in clinical settings and is the driving force behind any good training program. It is important that all students are assessed fairly and equitably. For the assessment to be student friendly, it is essential that:

- The students are provided with opportunities for learning and assessment.
- They are encouraged to self assess and reflect on their learning.
- Skills assessments are valid and reliable and that the level of skill can be consistently demonstrated.

Continuous assessment (formative assessment) is mostly suited in clinical placements, as it provides a measure of how the student is performing at each stage of their training. Assessment can be formal or informal and should include the application of theory to practice.

The practice learning outcomes require that the students have competencies and must show evidence of achievement under the following:

- Psychomotor, skill development
- Self awareness, reflection on practice
- Problem solving
- Communication
- Interactive and teamwork skills

The basic concepts regarding assessment are standards, reliability and validity. Some validated tools for clinical assessment will be used by mentors in the clinical setting for evaluation of a student's progress.

Methods of Assessments

The assessment activities will differ according to the year level, yet assessment is still over 100 marks as reflected in the following:

- NURS1000 - Clinical Placement I
 - Continuous assessment: a) Learning Contract 50 %
 - b) Reflective journaling 20 %
 - c) Skills Assessment 30 % x 70%
 - Objective Structured Clinical Examination: 30%
- NURS2000 - Clinical Placement II
 - Continuous Assessment: a) Learning Contract 40 %
 - b) Reflective journaling 30 %
 - c) Skills assessment 15 %
 - d) Case study (group) 15 % x 70%
 - Objective Structured Clinical Examination: 30%
- NURS3000 - Clinical Placement III
 - Continuous Assessment: a) Learning Contract 40 %
 - b) Skills assessment 10 %
 - c) Reflective journaling 20 %
 - d) Case Study (individual) 10 %
 - e) Performance Eval'n on Staff N & Charge N 20% x 70%
 - Objective Structured Clinical Examination: 30%

The ABNS faculty will have an active role in the support of the clinical assessment of students. This includes running curriculum awareness sessions and assessor workshops in clinical environments.

Competencies will be assessed following a period of teaching, supervision and practice. The student is to be assessed frequently to maintain the assessment strategy. Continuous feedback on progress is critical to the achievement of the competency at the specified level. It is important to note that this is not a general assessment of the overall impression of the student's work. The

assessment is to be conducted with specific reference to the competency statement and the objectives. In addition to the ongoing contact between the Mentor and the students three formal meetings will take place:

Initial interview

This will be held at the commencement of the placement. The tutor, mentor and the student will negotiate learning opportunities, which will facilitate the achievement of identified objectives/evidence of attainment. At this point the initial interview form will be completed.

Interim interview

This will be held midway through the placement. The tutor, mentor and the student will meet to evaluate the learning experience to date. The interim interview form will be completed.

Final interview

Continuous assessment of practice and feedback will have occurred throughout the placement. Towards the end of the placement a meeting between tutor, mentor and the student will be held to formalize the assessment of the evidence of attainment of the objectives and thus the achievement or non-achievement of the competencies at the specified level. The competency assessment documents will be completed as will be assessment of practice pro forma.

The completed documents must be returned to the relevant tutors, by the student, at predetermined times, in order to monitor progress. Failure to submit the documents will be deemed as non-achievement of the competency at the specified level and may result in a referral at the Examination Board.

Students must complete a timesheet in every practice placement and must ensure it is countersigned by the named mentor or other designated member of the clinical team, normally on a weekly basis. Timesheets are designated as part of the clinical assessment documents. Submission dates for timesheets are found within the

Assessment Schedule for each stage of the programme. It is important that timesheets are accurate as they are the only source of information from which the total number of clinical hours attended during the programme is calculated.

Clinical laboratory performance is evaluated both on a Pass/Fail basis and indication regarding the obtained level (mark). Each clinical evaluation received by a student must be signed by that student. The student's signature signifies only that the student has read the evaluation. The student may enter comments or responses on the evaluation form along with the comments of the nurse educator.

8. Other Relevant Policies

(i) Annual Leave

Holiday dates are scheduled within the programme and **cannot be changed as per student request**. Holiday dates are from **Sunday to Saturday inclusive**. When holiday dates are preceded and/or followed by practice placements you cannot guarantee being "off duty" on the Saturday before or Sunday following holiday and **must make your plans accordingly**. Local Public/Bank Holidays may not be observed when you are in clinical placement.

(ii) Withdrawal and Leave Of Absence Procedures

o Student Withdrawal Process

The Student Withdrawal Process is initiated by the student with the CEO/VPA. All students withdrawing from the program, whether by leave of absence, suspension, dismissal or academic failure, must complete the Student Withdrawal Process within seventy-two (72) hours of the official withdrawal date (normally the last day of class attendance). An extension can be granted by the CEO/ VPA. Student records, including transcripts and grade reports, cannot be

released until this process has been completed as noted on the form.

○ **Administrative Withdrawal**

Students who fail to notify the school of their desire to withdraw from classes, and/or stop attending classes without following the proper notification, will be considered to have resigned as of the last day of attendance. These students will be considered withdrawn within 72 hours of the last day of attendance. Without proper notification, nursing students could be suspended or dismissed from the nursing program as a result of a violation of the no-call, no-show policy.

Students who are absent from a course for two weeks, without proper notification, could be withdrawn from the course and APAS Committee will be systematically informed.

○ **Leave of Absence (LOA)**

Students who are in good standing and have at least 50% in the current nursing course may request a Leave of Absence for personal reasons for a period of up to one year. This request should be submitted in writing to the chairperson of the APAS Committee before the completion of the Student Withdrawal process. The request should include the beginning and ending dates and the reason for the request. The APAS Committee will provide written approval for the request assuming the student qualifies for the leave. A one-time LOA extension of up to a year may be granted upon written request using the above procedure. Students on approved LOA's have a reserved space in the student body upon their return to classes. A student approved for a LOA prior to the completion of a course (module) will have to repeat that entire course upon return from the leave.

- **Medical Leave of Absence**

Students may request a Medical LOA when illness, surgery or pregnancy complications prohibit completing a rotation. This request should be submitted in writing, with medical documentation, to the chairperson of the APAS Committee before completion of the Student Withdrawal Process. The request should include the beginning and projected ending dates. The written request and medical documentation **MUST** be received within 2 weeks of the initial verbal Medical Leave of Absence request. The APAS Committee will provide written approval for the request. A one-time LOA extension of up to a year may be granted upon written request using the above procedure.

- **Return from any Leave of Absence**

Students on an approved LOA are not required to reapply for admission to the school, but must initiate contact with the School Office as early in the academic term prior to the semester of return to indicate their intentions. Students returning from a Medical LOA must provide a release from their physician stating they have no activity limitations in order to return to school. Students returning from any LOA are governed by the current school policies and procedures in effect on their return.

- **Readmission Policies**

No guarantee of readmission is given by the School of Nursing to students who have withdrawn, failed, been administratively withdrawn, or suspended from the school. Students who have been dismissed from the school are not eligible for readmission. Students may begin the reapplication process after they have completed the Student Withdrawal Form and officially withdrawn from the current course or semester.

Each reapplication to Apollo Bramwell Nursing School is given careful review and individual consideration based on academic merit and adherence to school policy.

Chapter IV: Student Services

A wide range of student services is provided for Apollo Bramwell Nursing School students in support of academic, professional, and personal goals.

1. Counseling Services

The VPA together with the nurse educators are responsible for providing **confidential** counseling services to students with concerns about academic and personal issues on a walk-in or appointment basis. There is no charge for these services. Referrals for special concerns are also available.

2. Faculty Mentor

Each student is assigned to a school mentor who provides support and guidance outside the classroom. The ongoing relationship is the responsibility of the student and school mentor.

3. Student Orientation Program

The comprehensive orientation program provides assistance to new students as they make individual adjustments to the ABNS student role. Orientation elements include among other things:

- Brief History of ABNS
- An overview of the programme
- Student skills necessary to succeed in a Nursing course
- Details of school policies, rules and regulations, student services
- Presentation of information on administrative requirements, financial aid, general student information.
- An individual conference with a member of the academic staff.
- A tour of ABNS and ABH facilities

4. Relaying Communication

The school has a variety of communication avenues to inform students of official activities, procedures, and important dates. Students are responsible for reading and responding to notices distributed through the mailbox system and to notices placed on official bulletin boards.

4.1 Messages for students

The school's reception desk is staffed from 8:00 to 17:00 hours during academic sessions.

The caller should always state clearly if the message is an *emergency* and provide as much information as possible to help the staff respond appropriately.

4.2 Bulletin Boards.

There are two bulletin boards where ABNS concerns are posted. One is located at the basement of ABH, across the entrance to the staff canteen and the other one is at the foyer of ABNS offices in the 3rd floor. Students are responsible for checking these locations regularly and responding to information posted on the official boards.

4.3 School Cancellation notices

Decisions regarding cancellation or delay of classes due to inclement weather will be made by the CEO or designee. Students should use good judgment and exercise caution in attempting to attend class or clinical placement during inclement weather, particularly tropical cyclones and torrential rains. Transportation for clinical placement is the responsibility of the student regardless of the weather conditions.

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5. Maintenance of Student Records

5.1 General Guidelines

Apollo Bramwell Nursing School is required to maintain accurate and current records of all students. **All Student and Graduate records are stored in locked, fire-resistant file cabinets. The official Graduate records are kept for an indefinite period of time.**

The following guidelines apply to all students:

5.1.1 Change of Address/Telephone

Any change of address or telephone numbers of either the student or nearest relative /guardian should be reported to the School Office immediately

5.1.2 Marriage/Divorce

A student who changes his/her name while enrolled in the program must inform the School Office as soon as possible. If indicated, a copy of the marriage certificate will be placed in the student's record within thirty days of the marriage. Copies may be made without charge at the school. In the case of a divorce with name change, a copy of the legal affidavit must be submitted to the School Office. All other status changes should be reported directly to the School Office.

5.1.3 Student and graduate records are maintained in accordance with the following procedures:

Transcript. In order to prevent unauthorized persons from having access to a student's records, including grades, an official transcript will be furnished only upon written request by the student or graduate. This request can be mailed to the attention of the School Office.

An initial transcript is issued without charge. A fee will be charged for all transcripts after the first. Please allow a minimum of five working days to complete a request.

All transcripts sent or released to students are **UNOFFICIAL** and must be stamped as such. As a rule, unofficial transcripts are not acceptable for admission to other institutions or to certain employers. **OFFICIAL** transcripts will have the school seal imprinted on it and will be sent directly to the school or business for which it is intended. Students who owe a balance to the school after graduation or withdrawal are not eligible to request official or unofficial transcripts until the balance due is paid in full.

Academic Records.

Each student has the right to review his/her academic record through an appointment made with the School Office. The student or graduate must specify, by written waiver, any items to be released to a potential employer from that student's academic records.

Health Records.

A student or graduate can request a copy of his/her student health forms. This request must be submitted in writing to the CEO. There is no charge for this service, but please allow five working days to complete this request. This information can only be given to the student or graduate and cannot be released to any third party. Health records are kept on file for four (4) academic years from date of student withdrawal or graduation.

Directory Information

Student information such as name, address, telephone, date/place of birth, field of study, dates of attendance and awards/honors received is kept and maintained by the school. This information is considered private information. This information can't be released without consent of the student.

Student/Graduate Records

Records are maintained for each student and graduate to provide chronological and historical information regarding their enrollment in the program. Student Records are defined as:

1. All correspondence. (Removed upon graduation)
2. All official permission forms
3. Admissions Review sheet
4. Official acceptance letter
5. Official registration fee letter
6. Completed application for admission
7. Three official Estimates of Student's Suitability for Nursing forms
8. SC, HSC, Baccalaureate
9. Certificate of Birth
10. Certificate of Marriage, if applicable
11. Certificate of Name Change, if applicable

Upon graduation or withdrawal, an official transcript indicating all course work completed, cumulative grade point average, and date diploma was awarded are added to the student's record, along with all Clinical Laboratory Evaluation Tools.

6. Library Services and Policies

ABNS provides various library services for current students and staff of the school. Hours of operation are posted at the entrance to the library.

6.1 The Librarian

The librarian is available to assist students in searching for information. Books, journal articles, and information can be obtained by asking the librarian.

a. General Library Policies

1. Food and beverages are *not* permitted in the library.

2. Theft or defacement of library materials is considered academic dishonesty and carries the same consequence as any major conduct violation.
3. Books and materials within the Reserve Section must be accessed only in the presence of the library personnel.
4. Anyone creating a disturbance within the library may be asked to leave by the librarian.
5. All students must clear their library records before graduation, and/or withdrawal from the school. Students who do not return library materials before leaving the school may not receive transcript of records, may have grades held, may be billed for unreturned or damaged items and/or their clearance forms will not be signed.

6.3 Policies for Checking out Material

Due Dates and Extensions

- All materials are due before closing time on the due date.
- Extension of this check out time can be made with the librarian.
- Books may be extended (cf rules and regulations)
- Magazines, Journals, Reserve, and Reference items **cannot** be checked out.
- Monograph (books) will circulate for 1 week. Renewal is allowed if not needed by other users. Renewal over the telephone is permitted.

Returning Material

Return all library materials when the library is open or place in book drop outside the library. You are responsible for returning all materials in proper manner and condition.

6.4 Library Hours

Regular hours of operation are posted at the entrance to the library. During vacation periods, the hours of the library may vary. These hours will be posted in advance at the library.

Chapter V: Student Conduct & Discipline

1. Basis of Discipline

In accordance with the School's philosophy and goals, personal conduct of students is expected to reflect a mature level of respect for self and others. Students are to conduct themselves in a morally, legally, and socially acceptable manner at all times.

As a student nurse, you will be working alongside other students, staff of the school and practice placements, and the public. You are likely to be in contact with members of the public at particularly difficult and vulnerable periods of their lives; when they are patients, carers, relatives or concerned citizens. It is important that you recognize and accept the expectations and responsibilities you now carry as a student nurse.

School Regulations defines the obligations, responsibilities and entitlement of students following enrolment. It explains the standards of conduct expected and specifies the procedures which are followed when misconduct is alleged.

As a student nurse

- You need to be aware that you now carry a responsibility to ensure your behaviour reflects the standards set out in The Code of Conduct and Ethics for Nurses (NCM, 2007).

The Nursing Council of Mauritius is primarily concerned with protecting the public and as part of the mechanisms for ensuring this, it requires your VPA to complete a 'Declaration of Good Character' document which confirms to the NCM that your

character is sufficiently good to enable safe and effective practice and that there is an intention to comply with the code of professional conduct: standards for conduct, performance and ethics.

To facilitate this declaration and to ensure you are fit to continue to progress through your course, you are required to complete an annual declaration of Good Health and Good Character. Personal tutors co-ordinate the completion of the declaration at the end of each stage of the programme and review your submission with you.

The declaration provides an opportunity for you to discuss any new issues with your personal tutor and review any ongoing circumstances associated with health and conduct. It is important that you are open and honest in completing this declaration and that you use this process as a means of obtaining support and guidance.

The following guidelines and procedures have been established to provide students with clear expectations.

2. General Conduct

The following is a **non-inclusive** list of expected general behaviors and conduct.

- **As one representing the School**

Prior to engaging in any activity in which they represent themselves as a student of Apollo Bramwell Nursing School, students must be granted permission for the activity by the VPA or CEO.

- **Conduct in Classroom and Clinical Laboratory / Placement Area**

A. During laboratory activities, the student is to remain in the clinical or classroom area to which they are assigned. If it is

necessary to visit another unit or department, permission must be received from the nurse educator.

- B. For the safety of the patient, any student judged by the nurse educator to be unfit to provide safe care will not be allowed in the clinical laboratory area.
- C. Food, beverages, gum, and smoking are not allowed in any classroom and clinical laboratory area during the hours of courses delivery.
- D. Cell phones must be kept on silent mode both in theory classes and in the clinical setting. Students should avoid using cell phones during class or clinical time.
- E. The student must follow visitor regulations at all times when visiting acquaintances /family members who are patients at any facility.
- F. **Apollo Bramwell Nursing School is a non-smoking facility, therefore smoking is NOT permitted anywhere within the complex, including the buildings, or on the parking lots.**

3. Major Conduct Violations

The following is a **non-inclusive** list of actions considered to be serious violations of school policies and which may result in serious disciplinary action:

- A. Cheating or dishonesty regarding academic work is not tolerated in any theory or laboratory setting. Students are expected to do their own work. All sources of information, including print, electronic, or other students, must be credited or referenced to avoid charges of plagiarism.
- B. Physical or verbal assault or harassment, threats, disorderly conduct, disruptive behavior, creating a nuisance by noise, or the use of obscene or foul language.

- C. The threat, or possession of weapons, firearms, explosives, fireworks, or ammunition.
- D. The theft or unauthorized use/possession of school, hospital, or another person's property.
- E. Unauthorized use of ID cards for entry to school or hospital facilities.
- F. Tampering with or disabling emergency equipment.
- G. Making a false report, or failure, to comply with the directions of school/hospital employees acting within the scope of their assigned duties or position.
- H. Use, possession, or distribution of any controlled substance, unless legally prescribed by a physician. Use, possession, or distribution of alcoholic beverages on the hospital premises.

4. Certificate of Morality

You are subject to produce Certificate of Morality and your criminal record status must meet the requirements for entry to and continuation on a nursing programme. You must report (to your senior nurse educator) any situations you become involved with which leads to the involvement of the police or criminal proceedings, or call into question your good character or which might undermine the reputation of the profession, school or public safety or confidence.

In certain circumstances, your progression on the programme may be suspended until situations relating to any areas highlighted above have been resolved.

As a student nurse you are subject to Enhanced Disclosure procedures. It is important that all individuals who will work with the public at times when they are particularly vulnerable are scrutinized in terms of any criminal record to ensure that any risk to the public is minimized and public protection is enhanced.

A condition of your entry to the programme will have been a satisfactory Certificate of Morality. Without confirmation that a satisfactory Certificate of Morality has been received, you will **not** be able to access practice placements.

It is important that you inform the School through your personal tutor or the VPA and at the earliest opportunity, if there are any events that may impact on the status of your criminal record, for example, if you receive any cautions by police, if you are charged by the police, prosecuted or/and convicted of any crime. Such events do not necessarily prevent you from continuing and completing your programme of study however, they may constitute non academic misconduct and/or, in situations where the outcome is pending, you may not be permitted to access practice placements until the outcome is known.

On an annual basis you are required to sign a declaration that you continue to be of good health and of good character. Good character will include a declaration that there are no changes to your criminal record since the last Certificate of Morality check was undertaken.

5 Discipline and Due Process

5.1 Disciplinary Actions

Disciplinary actions normally occur in response to a violation of a school or hospital rule or policy. The general administration of the disciplinary program is the responsibility of the Admissions, Promotions, and Academic Standards (APAS) Committee. This committee oversees the disciplinary process for academic and non-academic matters.

Actions taken as a result of a specific situation are determined by:

- the details of the situation
- the seriousness of the violation, and
- the academic status and prior disciplinary history of the individual student or students involved.

The APAS committee may use *any* action(s) it considers appropriate in response to a violation. The above non-inclusive list is for illustration only; other actions may be implemented by the APAS committee. The list does not represent a step process (i.e., there is no obligation to begin with a written warning and proceed step-by-step through the actions in order); however the list is in relative order of seriousness in terms of potential impact on the student:

5.2 Written Warning. A written warning serves to notify a student that his/her behavior unacceptable. Normally results from report of violation by school or hospital personnel.

5.3 Disciplinary Probation. A student is placed on Disciplinary Probation due to an unacceptable behavior. Probation is for a specific length of time - up to the remainder of academic enrollment. Probation may include additional loss of privileges and is designed to prevent continued violations.

5.4 Suspension from the Program. A student is suspended for conduct or behavior that results in unethical, immoral, illegal or unsafe actions or violations of any school policy. A student can apply for readmission; however, appearance before the APAS Committee is required as part of the readmission process.

5.5 Dismissal from the Program. Dismissal from the program is the removal of a student from enrollment for a serious violation or continued failure to comply with school policies. Having been dismissed, the student is not eligible to apply for readmission.

5.6 Due Process. Due Process Rights and Appeals Procedure provide a fair method to resolve conflicts between parties and protect students from arbitrary, discriminatory, or unreasonable enforcement of school policies or actions.

○ **Due Process Rights**

The following listed rights are to insure that administrative proceedings, which involve disciplinary actions and/or grievances, are conducted in a fair and consistent manner. Each student involved in a disciplinary situation or who has a grievance has the right to:

1. File a written grievance or appeal.
2. Receive a written statement of charges and their basis, when applicable.
3. Know the nature of evidence/information being considered.
4. Present supporting evidence on his/her own behalf.
5. Request a personal appearance before the person or group.
6. Receive a timely response to the appeal or grievance.

○ **Grievance Process**

A grievance is any dissatisfaction, complaint or alleged injustice that results from an academic or non-academic experience with administrators, faculty/staff members, students.

○ **Basis For Making an Appeal**

It is the responsibility of the person making the appeal to demonstrate the validity of his/her reason for the appeal. A student has the right to appeal any action, based on one of the situations listed below:

1. The action taken is more severe than warranted based on the original situation.
2. New information was not available at the original decision.
3. Improper procedures, which altered the original decision.
4. Probable bias on the part of the decision-maker.

○ **Potential Results of an Appeal**

At each step of the appeals process, the *written appeal* will provide the basis for investigation of the appeal. However, as part of

deliberation or investigation, the appearance of some or all of the individuals involved may be requested. A written response to appeals at each level will be provided to the person appealing the decision. The possible results of an appeal are, that the original decision will be:

1. Upheld without change.
2. Increased in severity.
3. Modified in some way.
4. Completely rescinded.

o **General Process For Making An Appeal**

Written grievances must be submitted in person **within five working days** of the occurrence /decision to be considered. The student must initiate a meeting with the person(s) (student, committee or school/staff) directly involved in the occurrence or decision giving rise to the grievance and must attempt to resolve the problem with such person(s). (annexe)

- 5.6.1 Course Audit During Appeal Process.** While awaiting the outcome of the appeal process, a student has the opportunity to request to audit the currently enrolled course OR the next consecutive course, if appeal occurs at the conclusion of the course. **Auditing the course** refers to attending lecture only. The student cannot participate in clinical experience or take examinations/quizzes for theory. Request to audit the course must be approved by the General Manager. All clinical hours and tests must be made up if the resolution of the appeal is to continue in the program.

6 Non-Discrimination Statement

A separate process governs situations where an individual feels he/she has been discriminated against on the basis of race, color, religion, age, sex, marital status, national or ethnic origin, or disability in the administration of the school's educational policies, scholarship and loan program, and athletic or other school-administered programs. If an individual believes that he/she has

been subjected to such discrimination, he/she should contact the CEO.

- For Disciplinary cases that goes to the University of Mauritius Disciplinary Committee, a fee of MUR 6,000 to MUR 15,000 must be paid by the student/ case, as regulated by the Code of Discipline of the University of Mauritius

Chapter VI: Uniform & Dress Code

I. GENERAL PROVISIONS

1. Statement of Purpose

The clothing and personal appearance of students can impact on the public perception of the quality of services in school, in clinical placement and outside the school.

Our Uniform and Dress Code policy is designed to:

- Ensure the personal appearance of our students contributes to a positive, professional image and promotes confidence in the professionals they will become.
- Promote patient safety and the prevention and control of infection by ensuring that all students wear clothing that is appropriate during their clinical placement.

During clinical placement at Apollo Bramwell Hospital, Apollo Bramwell Nursing School student nurses will respect the ABH Uniform and Dress Code Policy as follows:

"We are committed to reducing the number of avoidable infections in Apollo Bramwell Hospital to give confidence to patients and their families by taking action that the public sees. The attitude and actions of every individual can make a difference and the objectives our Uniform and Dress Code policy are to ensure that all staff:

- Understand what they should be doing and why;
- Contribute to good infection control practice;
- Lead by example;

- Reassure others that we provide a professional service and that patient safety and infection prevention and control are of the highest priority.

2. Uniform Allowance

Students are given **two sets of uniforms for school per year. Extra sets can be ordered or purchased by the student.** Three sets of uniforms and one pair of shoes for clinical placement are likewise given before their first clinical placement. They must ensure that they are wearing the appropriate and complete uniform every time.

II. At school

1. Definition of the Non-Clinical Area

For the purpose of the Uniform and Dress Code policy, a “school area” is defined as any area wherever the students wear the ABNS uniform (school, bus, street, hospital, etc.).

2. Identification

Each student needs to present either his/her Access Card with a visible photo identity with name and position details clearly displayed at all times.

3. General Presentation and Appearance

3.1 Students should always maintain a professional image.

3.2 Students should look clean and tidy, and have a good standard of personal hygiene.

- Clothes should be free from obvious dirt and stains.
- Hair should be clean and tidy. For ladies, hair that falls below the collar should be secured away from the face in a style that does not need constant re-adjusting. For males, hair need to be short and good appearance, facial hair must be kept short, neatly trimmed and tidy.
- Make up should be discreet.
- Tattoos, if any, should not be visible.

- Nails should be clean and well manicured. Nails must be short and unvarnished. False nails are not permitted as they support fungal growth.
- Males must ensure that their underpants are tucked in properly.

4. Jewellery

- 4.1 No visible body piercing;
- 4.2 No more than one discreet nose stud;
- 4.3 No tongue studs permitted

5. School Uniform

ABNS provides a uniform and this uniform must be worn at all times by the students. The uniform must be adhered to and not be altered in anyway. Should replacement be necessary, students will have to pay for it.

5.1 Footwear for students should:

- 5.1.1 Be clean and in good repair, **black or navy blue** for both males and ladies;
- 5.1.2 Have covered toe, soft sole. **flip-flops or other 'beach-style' footwear is not allowed.**
- 5.1.3 Have not heels higher than 2 cm; stiletto heels are **not allowed** for health and safety reasons.

5.2 Upon completion of/or discontinuation from the program, the student must ensure that their uniforms are destroyed to prevent their misuse which might bring the name of ABNS into disrepute.

III. The Clinical Area

1. Definition of the Clinical Area

For the purpose of the Uniform and Dress Code policy, a clinical area is defined as any area within the hospital where patients receive treatment and care. This includes, for example, Wards, Outpatient Department, Diagnostic Areas, Operating Theatres, Emergency Room/s and Ambulances.

2. Wearing of Prescribed Uniform

- 2.1 The student shall report to the assigned area in complete uniform.
- 2.1.1 The complete uniform for both men and women shall be:
- Prescribed white blouse/shirt with ABNS logo and white slacks/trousers
 - Prescribed shoes and socks
 - Access cards / nameplate
- 2.1.2 The following accessories must be in the student's possession while on duty: a watch with second hand, a bandage scissors, black and red pens, a stethoscope and a penlight.
- 2.2 Any missing item in the uniform, e.g. nameplate, shall be counted as one late.
- 2.3 Uniforms must not be worn outside of the hospital premises.
- 2.4 When traveling to and from their placement, students must wear the school uniform.
- 2.5 During pregnancy, a student may wear a white coat.

3. Grooming

- 3.1 The student shall report to the assigned area properly groomed.
- 3.2 Uniforms shall be clean and neatly pressed, shoes well polished.
- 3.3 Only white underwear shall be worn when on duty.
- 3.4 The following guidelines for the hair shall be observed:
- 3.4.1 Long hair shall be kept away from the face, tied to the back and worn in a bun; short hair should not touch the collar.
- 3.4.2 Only a simple black hair accessory may be used
- 3.4.3 Highlighting is not allowed for both male and female students.

- 3.5 For the female student only a minimum of day make-up is permissible
- 3.6 Use of jewelry while in clinical placement shall be minimized to a wedding ring, one pair of plain, discreet ear studs and/or one discreet nose stud.
- 3.7 Fingernails shall be kept short, clean and without nail polish at all times
- 3.8 The student should be conscious of his/her hygiene. He/She should smell fresh and clean. The use of deodorant is encouraged. However, strong smelling perfumes should be avoided.

4. Maintenance of/Replacement of Uniforms

- 4.1 Clinical uniforms worn by students will be laundered by ABH. Dirty Uniforms should not be taken home
- 4.2 Students are expected to promptly change out of their uniforms at the end of each shift before leaving their workplace. Dirty uniforms should be disposed of properly on the linen skip inside the lockers.
- 4.3 Shared changing facilities and lockers are provided in a designated area of the hospital for students' use. Locker rooms should be kept tidy at all times.
- 4.4 Students are expected to follow the routine frequency for change of uniform and the circumstances where the uniform should be substituted immediately (in the event of contamination with blood or body fluids).

5. Non-Compliance with Uniform & Dress Policy

- 5.1 Students are expected to comply with the dress code of the clinical facility to which they are assigned. Failure to do so will result in dismissal from that clinical setting for the day.
- 5.2 If students are considered inappropriately dressed they will be given a verbal warning and will be sent off duty. This will be reported as an absence until the student returns dressed appropriately. The time associated with these absences will need to be made up. Following this first verbal warning any

second incident of breach in following the uniform policy will be considered unprofessional conduct and as a result the student will normally face disciplinary action.

Chapter VII: Other Policies

1. Health Requirements for Level One

Prior to the first day of classes, all students must submit a current physical examination. The School Office maintains student health records as part of the student's official file. Students will be denied access to clinical laboratory experiences regarding direct patient care until all required health forms are accepted.

2. Pregnancy

A student who becomes pregnant may continue in the program with the consent of her private physician. A written statement from the physician indicating that the student may continue with no activity restrictions must be submitted within the first trimester of the pregnancy to be filed in the student's record. If a complication arises, a Medical Leave of Absence (MLOA) may be requested – see Medical Leave of Absence Procedure in Student Handbook. In addition, a written release from the physician must also be provided upon the student's return to school after delivery.

3. Accidents and Incidents

If you are involved in an accident/incident during your course, (whether or not you are injured), are a witness to one or have one reported to you, you must inform a member of staff as soon as possible.

If you are on placement, the accident/incident should be reported immediately to the manager of the area and subsequently you should notify your Personal Tutor and the Clinical Instructor for the area.

To comply with Health and Safety regulations, appropriate records should be maintained. **ALL** accidents/incidents that occur within ABNS site or while undertaking practice placement **MUST** be recorded using the official documents used in the area concerned. You may also be required to complete a school incident form.

4. Fire Safety

It is the responsibility of individual students to make themselves aware of the procedure to be followed in the event of fire. Instructions are displayed in prominent areas throughout University buildings.

At the beginning of each practice placement you will receive an orientation and induction that will include information and instructions relating to health and safety procedures that are specific to the area of practice.

Chapter VIII: FINANCIAL SERVICE INFORMATION

Tuition

All tuition and fees are due between 5th day of each month

Payment is defined as a receipt for payment in full, a financial aid award letter showing funds for the term equal to or greater than your charges for the term on your registration form, approval to bill a third party for the full payment due, or a signed payment plan from the Accounting Department. If tuition is not paid or arrangements have not been made, by the first day of classes, ABNS reserves the right to cancel the student's registration. A student may not register for classes or graduate if a balance exists on their student account. Academic Transcripts will not be released if a past due balance exists on a student's account.

ALL FEES SHOWN ABOVE ARE NON-REFUNDABLE

All students must comply with the rules and regulations of the fees and payments as stipulated in the student's contract.



Chapter I Vision and Mission Statements

1. Vision

The Apollo Bramwell Nursing School shall be the best nursing school in Mauritius and the region and shall become internationally recognized as a Center of Excellence in Nursing Education.

Program development will be geared towards research and evidence-based practice and forging strong academic exchanges with international universities of repute.

2. Mission

Our mission is to strive to provide the highest level of nursing instruction and develop parallel courses for a holistic approach to nursing education in order to produce highly qualified and specialized nursing officers of the highest standards who can become tomorrow's leaders in the field of nursing and research.

3. Philosophy

The philosophy of Apollo Bramwell Nursing School is embodied in the following statements:

Human beings are unique, rational individuals possessing self-worth and dignity, deserving recognition of essential qualities: intellectual, psychological, physical, spiritual and social. Human beings can utilize their potential for self-development and self-improvement. People are capable of modifying their environment and their responses to it.

The **Environment** covers all influences the individual's internal responses, beliefs, values and experiences. Environment includes influences of culture,

INDUCTION PROGRAM FOR BATCH V

April 9 - 11, 2014

Wednesday - 09 April

- | | | |
|---------|---|--------|
| 9:00 am | Administrative Initiatives | Zareen |
| | <ul style="list-style-type: none"> Giving out of letter of acceptance from ABNS Signing of letter of acceptance by the student Signing of Contract & Confidentiality and Disclosure Agreement Payment of Registration and Tuition Fees Enrolment procedures Bus pass arrangements Uniform arrangements | |

12:00 Lunch Break

- | | | |
|---------|---|-------------------------------------|
| 1:00 pm | Welcome | Valerie |
| | <ul style="list-style-type: none"> Brief History of ABNS Introduction of ABNS staff An Overview of the DGN Program Student Services | Valerie
Mae
Mae
Zareen/Mae |

Thursday - 10 April

- | | | |
|-------|-------------------------------------|---------|
| 9:00 | What is your Learning Style? | Chottoo |
| | Time Management | Chottoo |
| 12:00 | Lunch break | |
| 1:00 | How to Succeed in a Nursing Course | Felzal |
| 2:00 | Challenges in a Diverse Environment | Mo |
| 3:00 | Tour of Apollo Bramwell Hospital | Cls |

Friday - 11 April

- | | | |
|-------|---|------------|
| 9:00 | ABNS Expectations of its Students | |
| | <ul style="list-style-type: none"> Corporate Policies School Policies | Doy
Mae |
| | Getting to Know You | |
| 12:00 | Lunch | |



APOLLO BRAMWELL NURSING SCHOOL
ORIENTATION PROGRAM -ADMINISTRATIVE
BATCH 5

WEDNESDAY 9 APRIL 2014

Start Time : 09.00am

- Sign Attendance Sheet
- Signature of ADMISSION ACCEPTANCE FORM by student
- Signature of 2 copies STUDENT CONTRACT (initial on all pages)
- Signature of CONFIDENTIALITY & DISCLOSURE AGREEMENT
- Payment of Registration and Tuition Fees
- Enrollment procedures – Fill enrollment form
- Module registration form
- Signature of list for BUS PASS and payment for Bus Pass
- Meeting with Bramer Bank Representative for Educational Loan
- Signature of Attendance Sheet

Break/ Lunch time:

- 10:15 – 10:30

Learning Styles Questionnaire

by Honey & Mumford

This questionnaire is designed to find out your preferred learning style. Over the years you have probably developed learning habits which help you benefit more from some experiences than others. Since you are probably unaware of this, this questionnaire will help you pinpoint your learning preferences, so that you are in a better position to select learning experiences to suit your style.

There is no time limit to this questionnaire. It will probably take 10-15 minutes. The accuracy of the results depend on how honest you can be. There are no right or wrong answers. If you agree more than you disagree with a statement, put a tick by it. If you disagree more than you agree put a cross. Be sure to mark each item either with a tick or a cross.

- | | | |
|--------------------------|----|---|
| ☐ | 1 | I like to be absolutely correct about things. |
| ☐ | 2 | I quite like to take risks. |
| ☐ | 3 | I prefer to solve problems using a step by step approach rather than guessing. |
| ☐ | 4 | I prefer simple, straightforward things rather than something complicated. |
| ☐ | 5 | I often do things just because I feel like it rather than thinking about it first. |
| ☐ | 6 | I don't often take things for granted. I like to check things out for myself. |
| ☐ | 7 | What matters most about what you learn is whether it works in practice. |
| ☐ | 8 | I actively seek out new things to do. |
| ☐ | 9 | When I hear about a new idea I immediately start working out how I can try it out. |
| ☐ | 10 | I am quite keen on sticking to fixed routines, keeping to timetables, etc. |
| ☐ | 11 | I take great care in working things out. I don't like jumping to conclusions. |
| ☐ | 12 | I like to make decisions very carefully and preferably after weighing up all the other possibilities first. |
| ☐ | 13 | I don't like 'loose ends', I prefer to see things fit into some sort of pattern. |
| ☐ | 14 | In discussions I like to get straight to the point. |
| ☐ | 15 | I like the challenge of trying something new and different. |
| ☐ | 16 | I prefer to think things through before coming to a conclusion. |
| ☐ | 17 | I find it difficult to come up with wild ideas off the top of my head. |
| ☐ | 18 | I prefer to have as many bits of information about a subject as possible, the more I have to sift through the better. |
| ☐ | 19 | I prefer to jump in and do things as they come along rather than plan things out in advance. |
| ☐ | 20 | I tend to judge other people's ideas on how they work in practice. |

- ☐ 21 I don't think that you can make a decision just because something feels right. You have to think about all the facts.
- ☐ 22 I am rather fussy about how I do things - a bit of a perfectionist.
- ☐ 23 In discussions I usually pitch in with lots of ideas.
- ☐ 24 In discussions I put forward ideas that I know will work.
- ☐ 25 I prefer to look at problems from as many different angles as I can before starting on them.
- ☐ 26 Usually I talk more than I listen.
- ☐ 27 Quite often I can work out more practical ways of doing things.
- ☐ 28 I believe that careful logical thinking is the key to getting things done.
- ☐ 29 If I have to write a formal letter I prefer to try out several rough workings before writing out the final version.
- ☐ 30 I like to consider all the alternatives before making my mind up.
- ☐ 31 I don't like wild ideas. They are not very practical.
- ☐ 32 It is best to look before you leap.
- ☐ 33 I usually do more listening than talking.
- ☐ 34 It doesn't matter how you do something, as long as it works.
- ☐ 35 I can't be bothered with rules and plans, they take all the fun out of things.
- ☐ 36 I'm usually the 'life and soul' of the party.
- ☐ 37 I do whatever I need to do, to get the job done.
- ☐ 38 I like to find out how things work.
- ☐ 39 I like meetings or discussion to follow a proper pattern and to keep to a timetable.
- ☐ 40 I don't mind in the least if things get a bit out of hand.

Scoring

For each question you ticked on the other sheets, put a '1' beside the question number on this sheet. Put nothing for crosses. Add up the 1s in each column.

1	4	2	11
3	7	5	12
6	9	8	16
10	14	15	18
13	20	19	21
17	24	23	25
22	27	26	29
28	31	35	30
38	34	36	32
39	37	40	33
Theorist	Pragmatist	Activist	Reflector

2014 Year Planner – Batch 5

2014	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T
January			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
February						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
March						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
April		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
May				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
June							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
July		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
August					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
September	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
October			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
November						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
December	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23

TIMETABLE FOR APRIL 2014 - BATCH 5

Week 2

Apr- Monday 7th		Apr - Tuesday - 8th		Apr - Wednesday 9th		Apr - Thursday 10th		Apr- Friday 11th	
am	pm	am	pm	am	pm	am	pm	am	pm
				INDUCTION TO DGN PROGRAM		INDUCTION TO DGN PROGRAM		INDUCTION TO DGN PROGRAM	

Week 3

Apr - Monday 14th		Apr - Tuesday - 15th		Apr - Wednesday 16th		Apr - Thursday 17th		Apr - Friday 18th	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:30 - 4:00
Nurs1001	Nurs 1007	Nurs1001	Nurs 1003	Nurs1001	Nurs 1008	Nurs 1002	Nurs 1003	Nurs 1002	Nurs 1008
BD Gunesh	C Aubdool	BD Gunesh	C Aubdool	BD Gunesh MFD Nierras	CJ Seegolam	BM Degorio	C Aubdool	BM Degorio	CJ Seegolam Mentorship Course

Week 4

Apr - Monday 21st		Apr - Tuesday - 22nd		Apr - Wednesday 23rd		Apr - Thursday 24th		Apr - Friday 25th	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:30 - 3:30
Nurs1001	Nurs 1007	Nurs1001	Nurs 1003	Nurs1001	Nurs 1008	Nurs 1002	Nurs 1003	Nurs 1002	Nurs 1008
BM Degorio MF Nierras	C Aubdool	BM Degorio	C Aubdool	BM Degorio MF Nierras	CJ Seegolam	BM Degorio	C Aubdool	BM Degorio	CJ Seegolam Mentorship Course

Week 5

Apr - Monday 28th		Apr - Tuesday - 29th		Apr - Wednesday 30th		May- Thursday 1st		May - Friday 2nd	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30	LABOR DAY Bank Holiday		8:00 - 12:00	1:30 - 3:30
Nurs1001	Nurs 1007	Nurs1001	Nurs 1003	Nurs1001	Nurs 1008			Nurs 1002	Nurs 1008
C Aubdool	C Aubdool	A Nathoo	C Aubdool	A Nathoo	CJ Seegolam			BM Degorio	CJ Seegolam Mentorship Course

Please, note down your email address as well as your facebook I.D so as it can help us to create a group so as to facilitate our lectures and to be able to share information.

Name:

email:

Facebook I.D

- | | | |
|--------------------------|-------------------------------|---------------------|
| ① Gavin :- | gavinsoodin@yahoo.com | Gavin Soodin |
| 2. Dwanika :- | niravdwanika@gmail.com | NEERAV DWANIK A |
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yndish suhanye.
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vijayaluxmi ashna 14ramgoolam@gmail.com

Ashna Ramgoolam

27. Chris. Inshduth Lallbeeharry → chrislallbeeharry@gmail.com → Chris lallbeeharry.

family, religion and community. Diversity of environment and the individual is respected at all times. Health care professionals should recognize the growing diversity of society and the need to provide culturally sensitive care. Health care professionals must also recognize their role to assess and analyze a client's situation in order to relate a variety of contexts ranging from individual patient encounters to the management of complex systems.

Health is a dynamic state of wellness. Health practices must be geared towards prevention of illness and promotion of wellness with an emphasis on primary and secondary preventive strategies. Promoting a healthy lifestyle enhances health. It involves the active participation of patients, families, and communities in decisions regarding their health, and in evaluating its quality and accessibility. Health care professionals have a responsibility to participate as "community partners" and advocate public policy for promotion and protection of the health of society.

Nursing is a complex, interactive profession that is an art and a science. Nursing provides specific scientific, evidence based support and assistance to individuals and/or families, managing information and technology, while also assuming a personal code of ethics and social responsibility. Nurses must have up-to-date clinical skills and abilities as critical thinkers and problem solvers. As primary care givers, nurses must be prepared to function in new health care settings and with multiple interdisciplinary team members designed to provide optimally coordinated care. Today's nurse strives to insure cost-effective care balanced with appropriate care and quality of services and health outcomes.

Education is a process resulting in the learner's cumulative, progressive acquisition of knowledge, skills, competencies, values, attitudes and outcomes. It requires an environment of active, creative, and innovative participation between teacher and learner. Nursing education seeks to be proactive in anticipating changes in health care and in responding appropriately to such changes to enhance the preparation of the graduate nurse. Learning is a self-directed, life-long process, geared towards

developing and demonstrating relevant competencies throughout one's professional practice.

ABNS is responsible for integrating its philosophy into the academic program. The School's responsibility to the student focuses on facilitating effective adult learning by providing an appropriate learning environment that promotes the acquisition of knowledge, skills, competencies, values, attitudes, and outcomes essential to the development of the professional entry-level nurse.

Teaching as scholarship encompasses both the mastery of knowledge as well as the presentation of information so that others might understand it. ABNS in the diploma program is encouraged to explore innovation in adult learning and demonstrate creativity in the delivery of the teaching-learning process.

4. Values

Our fundamental values are:

- 1) **Equal opportunity:** We support all communities by providing the same training for each student regardless of race, color or faith.
- 2) **Caring and trustworthiness:** We manage ourselves with integrity by being honest in our communication and conduct and by showing concern for the well-being of others.
- 3) **Respect for diversity:** We treat people with dignity regardless of who they are or what they believe in.
- 4) **Commitment to academic excellence:** We engage in our own learning and participate fully in the academic community's pursuit of knowledge.
- 5) **Team work** – We place a high premium on good working relationships amongst us as an essential key to accomplishing our goals.

5. Essential Competencies of the Graduate Nurse

The student will attain the following outcomes in knowledge, aptitude, skill, attitude, and values upon completion of the nursing program, and following successful entry as a professional nurse:

1. Demonstrate a specialized body of knowledge and skills essential for entry-level nursing practice in order to optimize client's health status in a diverse community and a variety of health care settings.
2. Recognize the implications of social-cultural, economic and political trends and their influences on the client's health status and the profession in order to carry out appropriate nursing responses.
3. Integrate critical thinking, effective communication, health teaching, and therapeutic nursing interventions, while implementing the nursing process.
4. Observe the Nursing Council of Mauritius Code of Ethics and project a positive image of the profession.
5. Demonstrate leadership and ability to collaborate with consumers and health care providers in a cost effective manner while providing care.
6. Acknowledge responsibility for personal and professional development through continuing education, lifelong learning and active community service.

6. Student Rights and Responsibilities

The following is a non-inclusive list of rights and responsibilities that each student shall be entitled to and abide by upon their enrollment in Apollo Bramwell Nursing School.

• **Academic Rights and Responsibilities**

1. The right to participate freely in class discussions, to offer opinions, and ask questions in regard to classroom presentations and clinical laboratory experiences. Students have the responsibility to become active rather than passive learners.

2. The right to the presence of a mentor in the clinical laboratory areas as the need arises; students have the responsibility to consult the mentor when questions or concerns arise.
3. The right to objective and fair evaluation of their theoretical and clinical laboratory performances. Grading systems will be carefully reviewed with students and faculty periodically for clarification and better student-faculty understanding.
4. The right to confidentiality in the student-instructor relationship; confidential information about the student will not be released without the knowledge or consent of the student, except in the case of potential danger to the student or another person.
5. The right to review their records subject to the published disclosure policies. Students are responsible for maintaining the accuracy of demographic information, such as address and name change.
6. It is a serious responsibility of students to be present in all timetabled classes, clinical placement rotation and meetings/activities organized by the academic staff, including counseling sessions and tutorials. Absence from these program activities will be met with appropriate sanction/penalty.
7. Students have the responsibility to treat all students, faculty and staff in a respectful manner and show consideration for other's views and opinions. Students have the responsibility to support other students' learning.

- **General Student's Rights and Responsibilities**

7. Students have the right to recognition and understanding of their individuality.
8. No student will be discriminated against on the basis of race, color, religion, age, sex marital status, national or ethnic origin, disability, or any other non-merit factor.
9. Students have the right to a responsible voice in the formulation of institutional policies affecting academic and student affairs. All reasonable actions will be taken to inform students of changes to policies, procedures, and costs prior to the actual effective change.

10. Students have the responsibility to abide by the rules, policies, and procedures of the school.
11. Disciplinary proceedings will be instituted for violation of policies and procedures published in the Student Handbook or as may be provided to the student during the academic year. It is the student's responsibility to be familiar with and abide by these rules and regulations.
12. Students have the right to appeal any decision they feel is unfair. It is the responsibility of the student to use the Grievance/Due Process procedures in the appropriate manner to redress any grievance.
13. Students have the right to a written copy of the rules, policies, and procedures that affect academic and student affairs, as well as written information regarding financial aid, school safety and security, and other consumer information issues.

Chapter II: Diploma in General Nursing

1. Aims and Objectives

Objectives

- To operate a School of Nursing where the students will acquire the necessary knowledge, skills and aptitudes to meet the requirements to function as Registered Nursing Officers in Mauritius and beyond.
- Establish, maintain and supply a pool of trained nurses to support the Apollo Bramwell Hospital, government hospitals and other private clinics in the region and beyond.
- Impart education and training in nursing and allied subjects for the diffusion of useful knowledge and skills relevant to the needs of the community and the country.

Aims

The overall aim of the educational programme is to prepare safe and competent practitioners, equipping them with the skills necessary to respond constructively to a changing health care environment, which means having a curriculum that:

- Fosters an enthusiasm for learning and develop skills which will enable students to identify their own learning needs, engage in personal and professional development and develop a commitment to lifelong learning.
- Develops in the student skills of enquiry, analysis and problem solving, which will result in professional, competent, reflective practitioners, able to integrate theory and research into practice.
- Engenders in students an insight into the needs of a wide range of client groups by facilitating students' understanding of a variety of perspective on health, ill-health and the educative, restorative and rehabilitative aspects of nursing practice.
- Is practice-led, research orientated and appropriate to addressing contemporary nursing issues in a variety of clinical settings.
- Enables students to develop effective practice in a multidisciplinary environment, promote inter-professional understanding, cooperation and communication for team working and contribute to maintaining and improving standard of care.
- Facilitates the preparation of practitioners who are fit to practice, purpose and award and enable registration with regulatory bodies to be licensed to practice.

2. Admission to the Program

2.1 General Entry Requirements

- HSC or GCE A-Level with 2 A levels or equivalent
or SC / GCE O-Level or equivalent with a pass in English and credit in 5 other subject including Science (Applicants having credit in English Language need to have credit in only 4 other subjects)
or SC / GCE O-Level or equivalent with at least 3 credits including English and at least 3 years relevant working experience together with any formal or informal learning/training supported by testimonials.

- Fosters an enthusiasm for learning and develop skills which will enable students to identify their own learning needs, engage in personal and professional development and develop a commitment to lifelong learning.
- Develops in the student skills of enquiry, analysis and problem solving, which will result in professional, competent, reflective practitioners, able to integrate theory and research into practice.
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or SC / GCE O-Level or equivalent with at least 3 credits including English and at least 3 years relevant working experience together with any formal or informal learning/training supported by testimonials.

exercise, illness and hypoglycemia; emotional, social and financial barriers to adherence with diabetes.

NURS 3001 - RESEARCH IN NURSING

Research in nursing, link with professional project for future nurses.

NURS 3002 - NURSING MANAGEMENT AND EDUCATION III

Health Education/Teaching in Clinical Setting - Introduction. Methods and Medium of Health Education. Health Education Agencies.

NURS 3003 - MIDWIFERY & OBSTETRICS II

High risks pregnancy. Post Partum. Complications in Pregnancy. Induction of labour, Preterm labour and Post maturity: Abnormalities of Labour; Abnormalities of puerperium; Obstetrical emergencies and operative obstetrics; Special cases.

NURS 3004 - MEDICAL AND SURGICAL NURSING II

Nursing Management of Patients with Renal and Urinary Disorders. Nursing Management of Patients with Neurological Disorders. Nursing Management of Patients with Disorders of Connective Tissue and Collagen Disorders. Nursing Management of the Elderly.

NURS 3005 - SPECIALISED NURSING II

Ophthalmology - Assessment of function of eyes. Diseases and disorders of eyes and their management.

Otorhinolaryngology (Disorders of ear, nose, throat) - Assessment of the function of Ear, Nose and Throat. Disorders and diseases of the Ear, Nose and Throat. Disorders of nose, Paranasal Sinuses, Throat and adenoids. Surgery and Nursing care. Dietetics: Diet in ENT diseases.

Cardiology - Nursing Management of Patients with Cardio-Vascular Circulatory and Haematological Disorders. Assessment of cardio-vascular functions. Management of patients with cardio-vascular diseases. Sample and request for blood transfusion. Safety checks and records for blood transfusion.

Burns - Definition and types of burns. Causes of burns. First Aid measures. Management of a patient with Burns. Accident & Emergency dept. General and specific Nursing care.

Oncology - Introduction. Nursing management of patient receiving oncologic treatment.

Plastic/Reconstructive Surgery - Types. Nursing implications in preparing patient for plastic/ reconstructive surgery.

Nephrology - Review of Anatomy and Physiology of renal system: Medicine; Surgery; Renal Nursing.

NURS 3006 - PROFESSIONAL PROJECT IN NURSING

Definition of professional project in nursing. Personal training and counseling about the professional project.

8. Non-discrimination statement

Apollo Bramwell Nursing School does not discriminate on the basis of race, color, religion, age, sex, marital status, national or ethnic origin, or disability in the administration of its educational policies, scholarship or other school administered programs.

If individuals believe that they have been subjected to such discrimination, they should contact the CEO.

9. Educational Policy

When an applicant is admitted to the Apollo Bramwell Nursing School, he/she is subject to all policies and procedures of the school. Admission to the school **carries no assurance of promotion, graduation, or awarding of a diploma.** Continuation as a student, promotion, and eventual graduation are dependent on the fulfillment of all academic requirements and compliance with all policies and procedures of the school. Failure to comply with these requirements may result adverse consequences, up to and including dismissal. If the student is dismissed, no assurance is given that he/she will be readmitted.

10. Changes to Policies and Procedures

All policies, procedures, requirements, and costs shown in this handbook are subject to change without prior notification. Students should check both their individual e-mailboxes and the official bulletin boards regularly for the most accurate and up to date information. All reasonable actions will be taken to inform students of changes to policies, procedures, and costs prior to the actual effective change.

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Chapter III: Academic Policies

The School's Academic Regulations apply to all educational provisions offered by the school which bears academic credit and detail procedures covering aspects of your experience such as student conduct, appeals, complaints and assessment.

1. Admissions, Promotions and Academic Standards (APAS) Committee

This school committee reviews reports of scholastic counseling, analyzes student progress, makes decisions regarding **admission, promotion, evaluation, graduation, and dismissal of students**. This committee also oversees the disciplinary process for academic and non-academic matters. As part of its deliberation or investigation, the APAS committee may request that an individual student appear before the committee. Students involved in adverse academic or non-academic situation may request a personal appearance before the committee.

2. Academic Load

All students shall carry the prescribed academic load for the term/year. This will include theory, laboratory and clinical placement.

3. Registration / Enrolment

(i) All students selected to attend courses at the School are required to register before starting their respective courses and at the beginning of each subsequent semester for the duration of the course enrolled.

(ii) Students are required to register in all modules offered in a semester, except in cases where an exemption from module/s has been approved by the Faculty Board. [The processing and approval of application for exemption from module will be subjected to the policy of the University of Mauritius in this regard.]

(iii) Except as with permission from the Vice President Academic a student may not enroll in units of study with a total value of more than 24 credit points in either semester one or two; or less than 3 credit points in the same period.

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- (iv) Information on the venue, date and time of registration will be communicated officially to selected applicants.
- (v) The deadline for late registration/de-registration of modules shall be at the end of week seven (7) of the semester.
- (vi) At the time of registration, all students are required to sign a statement undertaking that they will conform to the rules and regulations in force at the School.
- (vii) At the time of registration, all registered students are issued with a Student Identity Card which must be carried at all times and produced on request. A student who loses his/her Identity Card must inform the A/A Coordinator immediately. A duplicate card may be issued on payment of a fee, which is subject to change subsequently.
- (viii) For the purpose of registration, students will have to produce: original certificates (Birth, Marriage, Academic qualification, Identity card, Morality, reference letters), two passport size photos, and pay the registration fee.
- (ix) All students are required to state, at the time of registration, their address and other particulars. Any change in name or address must be notified immediately in writing to the A/A Coordinator. This also applies to any subsequent change in the information s/he has provided at registration.
- (x) All fees for the academic year are payable at the time of registration unless arrangements have been made with the School President. Results of the examination will be withheld for non-payment of fees due.
- (xi) A student is not allowed to register for any academic year if s/he has fees in arrears due to the School for a previous academic year, except for special permission of the School President.
- (xii) Arrangements may be made for students with special needs.
- (xiii) All students must fill in the Student Feedback Questionnaire as from mid-semester. They will be given until the end of the module registration period for the following semester to fill in the Questionnaire. Until and unless the Questionnaire will have been filled in, students will not be allowed to register for the modules for the following semester in view of

completing registration formalities. (UoM, Ch 3[3.4.1 v])

4. Termination of Registration (Ch 2, Section 2.2 General Regulations for Students, University of Mauritius)

- (i) A person shall cease to be a registered student of the School:
 - (a) when s/he has completed the scheme of study for which s/he is registered; a student's registration will lapse at the end of the semester in which s/he has successfully completed the minimum requirements for the award of the degree, diploma or certificate.
 - (b) if s/he withdraws from the School;
 - (c) during the period of his/her interruption of studies;
 - (d) if under any of ABNS Regulations s/he is required to withdraw from the School;
 - (e) if her/his Cumulative Point Average (CPA) remains below 50 for two consecutive registered semesters, unless decided otherwise by the Senate UoM;
 - o Any student whose registration had been terminated under sections (d), (e) above or who had withdrawn from the University as from the 3rd week after the beginning of the first semester of year one without submitting valid reason(s) at the time of application for withdrawal should not be admitted on the same programme until a period of one year upon termination of registration.
 - o Students whose CPA is less than 50 for two consecutive registered semesters may be allowed, subject to approval by Board of Examiners, APAS and Senate, to continue with the programmes provided:
 - i. at least 75% of the number of credits required for the degree have already been earned; and
 - ii. the maximum allowable duration of the programme, as specified in the structure, has not been exceeded.

- Requests for extension from such students will not be entertained and periods of interruption of study will count towards the maximum allowable duration, as per existing rule.

(ii) The Faculty Board will terminate the registration of students who had abandoned their programme of study.

5. Attendance and Progression

(i) The Diploma in General Nursing programme stipulates 100% attendance. A student will be required to attend regularly lectures, tutorials and other forms of instruction prescribed by her/his scheme of study and to complete the required elements that make up the Continuous Assessment component of the programme. Attendance of practical sessions and submission of reports by their appointed date/s are compulsory.

(ii) When the hours lost by absence reaches 20% of the hours of lecture, laboratory or clinical placement in a semester, the student shall be summoned to appear before the Academic Board (APAS) and will be asked to show cause why s/he should not be deemed to have failed to complete that unit of study.

- The following situations may be considered as excused absence:
 - a. Illness of student with supporting evidence;
 - b. The student has met an accident;
 - c. Family crisis [death, impending death of an immediate family member];
 - d. The Government proclaims suspension of school activities in case of natural calamity.

In all situations, except (d), a letter of explanation signed/attested to by a parent or guardian must form part of supporting evidence.

All other reasons for being absent are considered unexcused.

(iii) The Senate of the University of Mauritius may, on the recommendation of the Faculty Board and APAS, suspend or preclude from further study any student whose attendance or

progress is deemed to be unsatisfactory. (Ch 2 Sec 2.3 General Regulations for Students, University of Mauritius)

- (iv) Absence due to ill health must immediately be notified by the student to the Vice President Academic [VPA] through the Academic & Administrative Coordinator [AAC]. Inability to attend classes for any reason must notify, in writing, the VPA through the AAC, and supply relevant documentation (i.e. medical/ or attendance certificate). The documentation must be made available to the AAC as soon as possible after the absence. Final approval rests with the VPA. It will be the responsibility of the student to make up for missed events and to complete the relevant requirements.
- (v) Students who are unable to attend classes/clinical placement and examinations for reason of pregnancy/child delivery/ child care or major health problems must apply for leave beforehand. Such applications must be supported by relevant documentation (medical certificate/s indicating the expected date of delivery or reason/s of urgency, etc.)
- (vi) A student is expected to be punctual in reporting to class or clinical placement. One who comes in fifteen (15) minutes late may not be allowed to enter the class or clinical area by the Nurse Educator / Clinical Instructor / Mentor concerned. S/he will be marked absent. And the absence will be considered unexcused.
- (vii) A student is advised against going on early leave whether during class or clinical placement. Should an urgent situation arise that will necessitate ones leaving the premises/campus before the allotted time, the student must secure the consent of his/her programme coordinator if he/she is in school or his/her mentor or a clinical instructor when in clinical placement. Time incurred during early leaves will be counted against the hours required either in lectures or in clinical placement.
- (viii) Students whose progress, attendance or conduct during the semester is not satisfactory shall be given a written warning by the VPA.

- (ix) In case there is still no improvement, the matter shall be referred to APAS who will hear all parties concerned and decide on the necessary course of action. The decision of the APAS will be final and binding.
- (x) Additional Policies in Clinical Placement
 - a. A student may have five days excused absence in one year without penalty or sanction. Should the absence go beyond five days, replacement of days missed will be required.
 - b. A student who is unable to report for duty on a scheduled shift should call the nurse-in-charge of the department/ward at least 3 hours before the time s/he is expected to report. Failure to do so would incur a sanction of four (4) days replacement for time lost.
 - c. A student is to report 15 minutes before official duty time.

Reporting late for duty three (3) times would be considered one day unexcused absence, which in turn will incur a sanction to replace lost time by four (4) days.
 - d. When on clinical placement the student shall remain within the hospital premises for the entire period of the shift and shall not go out without the consent of the mentor/or clinical instructor. Should there be a need to leave the work post before the official time for dismissal the student must inform the nurse-in-charge or a clinical instructor before leaving the premises. Willful violation of this policy will be considered unauthorized early leave, a major misdemeanor, which shall be raised to APAS for disciplinary action.
 - e. A student reporting for duty or leaving the hospital premises is required to sign in or sign out on two logbooks, one in the department where s/he is assigned and the other with the security.
 - f. All absences beyond what is allowed in (a) will need to be replaced. This includes time counted as sanction for unexcused absences. Make-up duty must be completed within the time frame set by the Clinical Coordinator. If for any reason a student is unable to report for make-up duty, the same procedure will apply as in (b) (c) (d) (e).

- g. The Clinical Instructor has the right to relocate or dismiss a student from the clinical area if, in his professional judgment, the student is not prepared for work, the student's physical or mental health prohibits provision of safe care or if the student exhibits unprofessional behaviour (i.e. conflict, insubordination).
- h. The nursing programme does not permit mitigation against a 'fail' in clinical practice. This is to ensure client safety. Nursing students experiencing difficulties which may affect their performance in clinical practice must withdraw themselves from placement and seek support from the clinical coordinator. Mitigation may be permitted for placement hours and completion of placement learning outcomes.
- i. A student is expected to abide by the policies set by the institution / agency allocated for his/her clinical placement. Any violation of policy will be dealt with on a case to case basis.

6. The Credit System.

- (i) The DGN programme is based on a modular credit system. The programme abides by the guidelines set by the University of Mauritius, its awarding body.
- (ii) All modules are assigned a unit value. One unit represents at least 15 contact hours of lecture/recitation; at least 45 hours of laboratory/skills lab practicum/workshops and 90 hours of clinical placement/duty.
- (iii) **Minimum Credits for Award of Diploma:**
A minimum of 130 unit credits is required before the diploma is awarded. A total of 4660 hours of theoretical and clinical training [2320 theory / 2340 clinical] comprise the whole programme.
- (iv) **Assessment**
 - a. Each semester module will be assessed singly over 100 marks. Assessment will be based on a written examination of 2 to 3-hour duration and on continuous assessment done during the semester.

- Written examinations for modules will be carried out at the end of the semester according to the School Calendar. A written examination will count for 30% for all modules except in Research in Nursing and Professional Project in Nursing.
 - Continuous assessment may be based on assignments, laboratory work, seminars or any other assessment parameters stipulated in the course syllabus and should include at least two (2) assignments/tests per semester per module. Continuous assessment will count for 70% for all modules except in Research in Nursing and Professional Project in Nursing which have separate criteria for assessment.
 - An overall total of 50% for combined continuous assessment and written examination components would be required to pass the module, other than those with separate criteria mentioned above, with minimum thresholds within the individual continuous assessment and written examination.
- b. The Clinical Placement modules found in each year level of the programme are assessed at the end of the academic year. Assessment in these modules are guided by a Clinical Assessment Framework [see annex 1].
 - c. For Quality Assurance purposes, the final written examinations at the end of the semester are moderated by an External Examiner, as recommended by the University of Mauritius.
 - d. Examination results shall be approved by the Faculty Board, then presented to APAS for recommendation to the Senate Examinations Sub Committee for approval through the Examinations Office (as stated in the revised procedure for processing examination results, as approved by Senate at its 544th (Ordinary) Meeting held on 07 November 2012.)

** Same procedure applies for processing of Continuous Assessment results, which is done simultaneously with that of Written Examinations.*

e. Late or Non- Submission of Continuous Assessment.

- Unless Special Consideration or an extension has been granted, students are required to submit all assessment for a module on the specified due date. Failure to do so will normally incur penalties.
- If an extension is either not sought, not granted or is granted but work is submitted after the extended due date, the late submission of assessment will result in academic penalty as follows:
 - * for work submitted after the deadline but up to seven (7) calendar days late, a penalty of 2 per cent per day of the maximum mark awardable for the assignment will apply;
 - * for work submitted after 13 calendar days and less than two weeks after the deadline, a penalty of 5 per cent per day of the maximum awardable mark for the assignment will apply;
 - * for work submitted more than two weeks after deadline will be awarded a zero mark.
- Students who fail to submit or take part in Continuous Assessment for medical or other special reasons shall normally be assessed before the written examination.
- A student who fails to submit/take part in a Continuous Assessment activity due to medical/financial/other reasons (may be in 1 or both components of the module) will be given a mark of N in the final grading. Removal of such N mark should be done prior to enrolment in the succeeding semester if the module is a prerequisite to one that is offered in the next semester. Otherwise, the student is given a 1 year period where the (N) grade may be removed.

- f. Special Consideration for illness, injury or misadventure
- Special Consideration is a process that affords equal opportunity to students who have experienced circumstances that adversely impact their ability to adequately complete an assessment task in a module. The procedure for applying for Special Consideration should be observed.
 - The faculty does not offer opportunities for re-assessment other than on the grounds of approved Special Consideration.
 - A student who has successfully requested Special Consideration may be allowed to sit an exam or submit required course work on an alternative date determined by the faculty. In normal circumstances, further sittings of end of semester examinations will be scheduled during the two weeks following the School's formal examination period. The student will be given at least three days notice of the timing of a test. Marks will be awarded at full value for re-assessment where Special Consideration is approved. Non-submission of work or non-attendance at exams by the agreed time will be considered a failure of the assessment item.
 - Where students are unable to complete a clinical placement due to illness, injury or misadventure and Special Consideration has been granted, they will be required to make up all the missed time.
- g. Attendance in formal or informal examinations.
- A student is expected to attend 100% of clinical placement activities and a minimum of 80% of timetabled activities for a unit of study, unless granted exemption by the APAS. The APAS may determine that a student fails a module because of inadequate attendance. Alternatively, at the

Academic Committee's discretion, it may set additional assessment items where attendance is lower than 80%.

Attendance will be monitored and may be used by the Board of Examiners while making recommendations to APAS / Senate Examinations Sub-Committee/Senate. (as amended in 30 January 2013 under Section 2.3 of the University Regulations, University of Mauritius)

- A student who attends less than 80% of the above will not be allowed to take part in the Written Examination nor will his/her assignments/portfolios be considered for assessment and will be considered as failed unless under exceptional circumstances.
- A student is required to be in attendance at the correct time and place of any formal or informal examinations. Non-attendance on any grounds insufficient to claim Special Consideration will result in forfeiture of marks associated with the assessment and may result in a failing mark for the module.
- A student who fails to sit for one or more examination paper/s, or to submit an assignment on the grounds of exceptional circumstances or illness, supported by medical certificate/s, may be given special examination/s in the paper concerned in the following semester.
- In case of illness, a Medical Certificate must be submitted to the AAC at latest **two days after** the examination. The School reserves the right to have a candidate examined by a doctor appointed by the School. In all cases the School must be satisfied with the evidence submitted.

h. Deferral of examination/assignments/research paper

- Deferral of an examination may be granted on the following grounds: ill-health or injury and other special grounds considered appropriate by the VPA;
 - A student who wishes to defer an examination in a module must apply in writing to the VPA, for special consideration, setting out the grounds on which deferral is sought and provide sufficient evidence;
 - A student who has valid grounds for consideration of deferral of the submission of a research paper/assignment may apply in writing to the VPA for an extension time to submit the assignment;
 - Request for extension should be made two weeks before the end of the semester or the prescribed date of submission.
- i. Referred/Failed Candidates
- Nursing students will be offered a reassessment opportunity for any theory module or component of a theory module where they have failed to achieve the minimum of 50%. Any reassessment will be capped at 50%.
 - A student with a final result of less than 50% in Continuous Assessment in modules other than Clinical Placement will be required to repeat the module when it is offered next.
 - A student with a result less than 50% in the Written Examination needs to take a resit examination, even if the total rating for the module is more than 50%. Not more than two resits for any referred module will be given.
 - A student who fails in the Written Examination will take his/her resit examination as soon as possible, given

procedural constraints. Should a second resit be needed the same shall be given a month after the first resit.

- o In case a candidate still fails after two resits, the matter will be referred to the Senate of the University of Mauritius by APAS for necessary action.
 - o The maximum number of modules that a candidate is allowed to be referred should not exceed one third (1/3) of the total number of modules offered in that semester.
 - o Students may be offered an opportunity to repeat the whole module (even where only a component of a module is failed) in the following academic year depending on funding arrangements and the requirement they can complete the programme within five years.
- (v) The School will be guided by the policy of the University of Mauritius in regard to restrictions in permitting a student to follow a module, retake a module/s and repeat/re-registration of students on the programme under extenuating circumstances.
- (vi) Academic Standing and Awards
- a. The ABNS abides by the stipulated policy of the University of Mauritius, its awarding body, in determining the academic standing of students.
 - b. The faculty will monitor students for satisfactory progress towards the completion of their program. In addition to the common triggers used to identify students not meeting academic progression requirements (as reflected in the progression requirements of each module), students must satisfy any requirements identified in the course resolutions as being critical to progression through the course (e.g. number of hours completed in clinical placement)

- c. The award classification will be based on the Cumulative Point Average (CPA) at the end of the Programme of Studies as follows:

Diploma with DISTINCTION	CPA ≥ 70
Diploma at PASS level	CPA $50 \leq x < 70$

7. Clinical Assessment Framework

Assessment is a critical element of the mentoring process in clinical settings and is the driving force behind any good training program. It is important that all students are assessed fairly and equitably. For the assessment to be student friendly, it is essential that:

- The students are provided with opportunities for learning and assessment.
- They are encouraged to self assess and reflect on their learning.
- Skills assessments are valid and reliable and that the level of skill can be consistently demonstrated.

Continuous assessment (formative assessment) is mostly suited in clinical placements, as it provides a measure of how the student is performing at each stage of their training. Assessment can be formal or informal and should include the application of theory to practice.

The practice learning outcomes require that the students have competencies and must show evidence of achievement under the following:

- Psychomotor, skill development
- Self awareness, reflection on practice
- Problem solving
- Communication
- Interactive and teamwork skills

The basic concepts regarding assessment are standards, reliability and validity. Some validated tools for clinical assessment will be used by mentors in the clinical setting for evaluation of a student's progress.

Methods of Assessments

The assessment activities will differ according to the year level, yet assessment is still over 100 marks as reflected in the following:

- NURS1000 - Clinical Placement I
 - Continuous assessment: a) Learning Contract 50 %
 - b) Reflective journaling 20 %
 - c) Skills Assessment 30 % x 70%
 - Objective Structured Clinical Examination: 30%
- NURS2000 - Clinical Placement II
 - Continuous Assessment: a) Learning Contract 40 %
 - b) Reflective journaling 30 %
 - c) Skills assessment 15 %
 - d) Case study (group) 15 % x 70%
 - Objective Structured Clinical Examination: 30%
- NURS3000 - Clinical Placement III
 - Continuous Assessment: a) Learning Contract 40 %
 - b) Skills assessment 10 %
 - c) Reflective journaling 20 %
 - d) Case Study (individual) 10 %
 - e) Performance Eval'n on Staff N & Charge N 20% x 70%
 - Objective Structured Clinical Examination: 30%

The ABNS faculty will have an active role in the support of the clinical assessment of students. This includes running curriculum awareness sessions and assessor workshops in clinical environments.

Competencies will be assessed following a period of teaching, supervision and practice. The student is to be assessed frequently to maintain the assessment strategy. Continuous feedback on progress is critical to the achievement of the competency at the specified level. It is important to note that this is not a general assessment of the overall impression of the student's work. The

Methods of Assessments

The assessment activities will differ according to the year level, yet assessment is still over 100 marks as reflected in the following:

o **NURS1000 – Clinical Placement I**

Continuous assessment:	a) Learning Contract	50 %	
	b) Reflective journaling	20 %	
	c) Skills Assessment	30 %	x 70%
Objective Structured Clinical Examination:			30%

assessment is to be conducted with specific reference to the competency statement and the objectives. In addition to the ongoing contact between the Mentor and the students three formal meetings will take place:

Initial interview

This will be held at the commencement of the placement. The tutor, mentor and the student will negotiate learning opportunities, which will facilitate the achievement of identified objectives/evidence of attainment. At this point the initial interview form will be completed.

Interim interview

This will be held midway through the placement. The tutor, mentor and the student will meet to evaluate the learning experience to date. The interim interview form will be completed.

Final interview

Continuous assessment of practice and feedback will have occurred throughout the placement. Towards the end of the placement a meeting between tutor, mentor and the student will be held to formalize the assessment of the evidence of attainment of the objectives and thus the achievement or non-achievement of the competencies at the specified level. The competency assessment documents will be completed as will be assessment of practice pro forma.

The completed documents must be returned to the relevant tutors, by the student, at predetermined times, in order to monitor progress. Failure to submit the documents will be deemed as non-achievement of the competency at the specified level and may result in a referral at the Examination Board.

Students must complete a timesheet in every practice placement and must ensure it is countersigned by the named mentor or other designated member of the clinical team, normally on a weekly basis. Timesheets are designated as part of the clinical assessment documents. Submission dates for timesheets are found within the

Assessment Schedule for each stage of the programme. It is important that timesheets are accurate as they are the only source of information from which the total number of clinical hours attended during the programme is calculated.

Clinical laboratory performance is evaluated both on a Pass/Fail basis and indication regarding the obtained level (mark). Each clinical evaluation received by a student must be signed by that student. The student's signature signifies only that the student has read the evaluation. The student may enter comments or responses on the evaluation form along with the comments of the nurse educator.

8. Other Relevant Policies

(i) Annual Leave

Holiday dates are scheduled within the programme and **cannot be changed as per student request**. Holiday dates are from **Sunday to Saturday inclusive**. When holiday dates are preceded and/or followed by practice placements you cannot guarantee being "off duty" on the Saturday before or Sunday following holiday and **must make your plans accordingly**. Local Public/Bank Holidays may not be observed when you are in clinical placement.

(ii) Withdrawal and Leave Of Absence Procedures

o Student Withdrawal Process

The Student Withdrawal Process is initiated by the student with the CEO/VPA. All students withdrawing from the program, whether by leave of absence, suspension, dismissal or academic failure, must complete the Student Withdrawal Process within seventy-two (72) hours of the official withdrawal date (normally the last day of class attendance). An extension can be granted by the CEO/ VPA. Student records, including transcripts and grade reports, cannot be

released until this process has been completed as noted on the form.

○ **Administrative Withdrawal**

Students who fail to notify the school of their desire to withdraw from classes, and/or stop attending classes without following the proper notification, will be considered to have resigned as of the last day of attendance. These students will be considered withdrawn within 72 hours of the last day of attendance. Without proper notification, nursing students could be suspended or dismissed from the nursing program as a result of a violation of the no-call, no-show policy.

Students who are absent from a course for two weeks, without proper notification, could be withdrawn from the course and APAS Committee will be systematically informed.

○ **Leave of Absence (LOA)**

Students who are in good standing and have at least 50% in the current nursing course may request a Leave of Absence for personal reasons for a period of up to one year. This request should be submitted in writing to the chairperson of the APAS Committee before the completion of the Student Withdrawal process. The request should include the beginning and ending dates and the reason for the request. The APAS Committee will provide written approval for the request assuming the student qualifies for the leave. A one-time LOA extension of up to a year may be granted upon written request using the above procedure. Students on approved LOA's have a reserved space in the student body upon their return to classes. A student approved for a LOA prior to the completion of a course (module) will have to repeat that entire course upon return from the leave.

- **Medical Leave of Absence**

Students may request a Medical LOA when illness, surgery or pregnancy complications prohibit completing a rotation. This request should be submitted in writing, with medical documentation, to the chairperson of the APAS Committee before completion of the Student Withdrawal Process. The request should include the beginning and projected ending dates. The written request and medical documentation **MUST** be received within 2 weeks of the initial verbal Medical Leave of Absence request. The APAS Committee will provide written approval for the request. A one-time LOA extension of up to a year may be granted upon written request using the above procedure.

- **Return from any Leave of Absence**

Students on an approved LOA are not required to reapply for admission to the school, but must initiate contact with the School Office as early in the academic term prior to the semester of return to indicate their intentions. Students returning from a Medical LOA must provide a release from their physician stating they have no activity limitations in order to return to school. Students returning from any LOA are governed by the current school policies and procedures in effect on their return.

- **Readmission Policies**

No guarantee of readmission is given by the School of Nursing to students who have withdrawn, failed, been administratively withdrawn, or suspended from the school. Students who have been dismissed from the school are not eligible for readmission. Students may begin the reapplication process after they have completed the Student Withdrawal Form and officially withdrawn from the current course or semester.

Each reapplication to Apollo Bramwell Nursing School is given careful review and individual consideration based on academic merit and adherence to school policy.

Chapter IV: Student Services

A wide range of student services is provided for Apollo Bramwell Nursing School students in support of academic, professional, and personal goals.

1. Counseling Services

The VPA together with the nurse educators are responsible for providing **confidential** counseling services to students with concerns about academic and personal issues on a walk-in or appointment basis. There is no charge for these services. Referrals for special concerns are also available.

2. Faculty Mentor

Each student is assigned to a school mentor who provides support and guidance outside the classroom. The ongoing relationship is the responsibility of the student and school mentor.

3. Student Orientation Program

The comprehensive orientation program provides assistance to new students as they make individual adjustments to the ABNS student role. Orientation elements include among other things:

- Brief History of ABNS
- An overview of the programme
- Student skills necessary to succeed in a Nursing course
- Details of school policies, rules and regulations, student services
- Presentation of information on administrative requirements, financial aid, general student information.
- An individual conference with a member of the academic staff.
- A tour of ABNS and ABH facilities

4. Relaying Communication

The school has a variety of communication avenues to inform students of official activities, procedures, and important dates. Students are responsible for reading and responding to notices distributed through the mailbox system and to notices placed on official bulletin boards.

4.1 Messages for students

The school's reception desk is staffed from 8:00 to 17:00 hours during academic sessions.

The caller should always state clearly if the message is an *emergency* and provide as much information as possible to help the staff respond appropriately.

4.2 Bulletin Boards.

There are two bulletin boards where ABNS concerns are posted. One is located at the basement of ABH, across the entrance to the staff canteen and the other one is at the foyer of ABNS offices in the 3rd floor. Students are responsible for checking these locations regularly and responding to information posted on the official boards.

4.3 School Cancellation notices

Decisions regarding cancellation or delay of classes due to inclement weather will be made by the CEO or designee. Students should use good judgment and exercise caution in attempting to attend class or clinical placement during inclement weather, particularly tropical cyclones and torrential rains. Transportation for clinical placement is the responsibility of the student regardless of the weather conditions.

Each reapplication to Apollo Bramwell Nursing School is given careful review and individual consideration based on academic merit and adherence to school policy.

Chapter IV: Student Services

A wide range of student services is provided for Apollo Bramwell Nursing School students in support of academic, professional, and personal goals.

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5. Maintenance of Student Records

5.1 General Guidelines

Apollo Bramwell Nursing School is required to maintain accurate and current records of all students. **All Student and Graduate records are stored in locked, fire-resistant file cabinets. The official Graduate records are kept for an indefinite period of time.**

The following guidelines apply to all students:

5.1.1 Change of Address/Telephone

Any change of address or telephone numbers of either the student or nearest relative /guardian should be reported to the School Office immediately

5.1.2 Marriage/Divorce

A student who changes his/her name while enrolled in the program must inform the School Office as soon as possible. If indicated, a copy of the marriage certificate will be placed in the student's record within thirty days of the marriage. Copies may be made without charge at the school. In the case of a divorce with name change, a copy of the legal affidavit must be submitted to the School Office. All other status changes should be reported directly to the School Office.

5.1.3 Student and graduate records are maintained in accordance with the following procedures:

Transcript. In order to prevent unauthorized persons from having access to a student's records, including grades, an official transcript will be furnished only upon written request by the student or graduate. This request can be mailed to the attention of the School Office.

An initial transcript is issued without charge. A fee will be charged for all transcripts after the first. Please allow a minimum of five working days to complete a request.

All transcripts sent or released to students are **UNOFFICIAL** and must be stamped as such. As a rule, unofficial transcripts are not acceptable for admission to other institutions or to certain employers. **OFFICIAL** transcripts will have the school seal imprinted on it and will be sent directly to the school or business for which it is intended. Students who owe a balance to the school after graduation or withdrawal are not eligible to request official or unofficial transcripts until the balance due is paid in full.

Academic Records.

Each student has the right to review his/her academic record through an appointment made with the School Office. The student or graduate must specify, by written waiver, any items to be released to a potential employer from that student's academic records.

Health Records.

A student or graduate can request a copy of his/her student health forms. This request must be submitted in writing to the CEO. There is no charge for this service, but please allow five working days to complete this request. This information can only be given to the student or graduate and cannot be released to any third party. Health records are kept on file for four (4) academic years from date of student withdrawal or graduation.

Directory Information

Student information such as name, address, telephone, date/place of birth, field of study, dates of attendance and awards/honors received is kept and maintained by the school. This information is considered private information. This information can't be released without consent of the student.

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Student/Graduate Records

Records are maintained for each student and graduate to provide chronological and historical information regarding their enrollment in the program. Student Records are defined as:

1. All correspondence. (Removed upon graduation)
2. All official permission forms
3. Admissions Review sheet
4. Official acceptance letter
5. Official registration fee letter
6. Completed application for admission
7. Three official Estimates of Student's Suitability for Nursing forms
8. SC, HSC, Baccalaureate
9. Certificate of Birth
10. Certificate of Marriage, if applicable
11. Certificate of Name Change, if applicable

Upon graduation or withdrawal, an official transcript indicating all course work completed, cumulative grade point average, and date diploma was awarded are added to the student's record, along with all Clinical Laboratory Evaluation Tools.

6. Library Services and Policies

ABNS provides various library services for current students and staff of the school. Hours of operation are posted at the entrance to the library.

6.1 The Librarian

The librarian is available to assist students in searching for information. Books, journal articles, and information can be obtained by asking the librarian.

a. General Library Policies

1. Food and beverages are *not* permitted in the library.

2. Theft or defacement of library materials is considered academic dishonesty and carries the same consequence as any major conduct violation.
3. Books and materials within the Reserve Section must be accessed only in the presence of the library personnel.
4. Anyone creating a disturbance within the library may be asked to leave by the librarian.
5. All students must clear their library records before graduation, and/or withdrawal from the school. Students who do not return library materials before leaving the school may not receive transcript of records, may have grades held, may be billed for unreturned or damaged items and/or their clearance forms will not be signed.

6.3 Policies for Checking out Material

Due Dates and Extensions

- All materials are due before closing time on the due date.
- Extension of this check out time can be made with the librarian.
- Books may be extended (cf rules and regulations)
- Magazines, Journals, Reserve, and Reference items **cannot** be checked out.
- Monograph (books) will circulate for 1 week. Renewal is allowed if not needed by other users. Renewal over the telephone is permitted.

Returning Material

Return all library materials when the library is open or place in book drop outside the library. You are responsible for returning all materials in proper manner and condition.

6.4 Library Hours

Regular hours of operation are posted at the entrance to the library. During vacation periods, the hours of the library may vary. These hours will be posted in advance at the library.

Chapter V: Student Conduct & Discipline

1. Basis of Discipline

In accordance with the School's philosophy and goals, personal conduct of students is expected to reflect a mature level of respect for self and others. Students are to conduct themselves in a morally, legally, and socially acceptable manner at all times.

As a student nurse, you will be working alongside other students, staff of the school and practice placements, and the public. You are likely to be in contact with members of the public at particularly difficult and vulnerable periods of their lives; when they are patients, carers, relatives or concerned citizens. It is important that you recognize and accept the expectations and responsibilities you now carry as a student nurse.

School Regulations defines the obligations, responsibilities and entitlement of students following enrolment. It explains the standards of conduct expected and specifies the procedures which are followed when misconduct is alleged.

As a student nurse

- You need to be aware that you now carry a responsibility to ensure your behaviour reflects the standards set out in The Code of Conduct and Ethics for Nurses (NCM, 2007).

The Nursing Council of Mauritius is primarily concerned with protecting the public and as part of the mechanisms for ensuring this, it requires your VPA to complete a 'Declaration of Good Character' document which confirms to the NCM that your

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The Nursing Council of Mauritius is primarily concerned with protecting the public and as part of the mechanisms for ensuring this, it requires your VPA to complete a 'Declaration of Good Character' document which confirms to the NCM that your

character is sufficiently good to enable safe and effective practice and that there is an intention to comply with the code of professional conduct: standards for conduct, performance and ethics.

To facilitate this declaration and to ensure you are fit to continue to progress through your course, you are required to complete an annual declaration of Good Health and Good Character. Personal tutors co-ordinate the completion of the declaration at the end of each stage of the programme and review your submission with you.

The declaration provides an opportunity for you to discuss any new issues with your personal tutor and review any ongoing circumstances associated with health and conduct. It is important that you are open and honest in completing this declaration and that you use this process as a means of obtaining support and guidance.

The following guidelines and procedures have been established to provide students with clear expectations.

2. General Conduct

The following is a **non-inclusive** list of expected general behaviors and conduct.

- **As one representing the School**

Prior to engaging in any activity in which they represent themselves as a student of Apollo Bramwell Nursing School, students must be granted permission for the activity by the VPA or CEO.

- **Conduct in Classroom and Clinical Laboratory / Placement Area**

A. During laboratory activities, the student is to remain in the clinical or classroom area to which they are assigned. If it is

necessary to visit another unit or department, permission must be received from the nurse educator.

- B. For the safety of the patient, any student judged by the nurse educator to be unfit to provide safe care will not be allowed in the clinical laboratory area.
- C. Food, beverages, gum, and smoking are not allowed in any classroom and clinical laboratory area during the hours of courses delivery.
- D. Cell phones must be kept on silent mode both in theory classes and in the clinical setting. Students should avoid using cell phones during class or clinical time.
- E. The student must follow visitor regulations at all times when visiting acquaintances /family members who are patients at any facility.
- F. **Apollo Bramwell Nursing School is a non-smoking facility, therefore smoking is NOT permitted anywhere within the complex, including the buildings, or on the parking lots.**

3. Major Conduct Violations

The following is a **non-inclusive** list of actions considered to be serious violations of school policies and which may result in serious disciplinary action:

- A. Cheating or dishonesty regarding academic work is not tolerated in any theory or laboratory setting. Students are expected to do their own work. All sources of information, including print, electronic, or other students, must be credited or referenced to avoid charges of plagiarism.
- B. Physical or verbal assault or harassment, threats, disorderly conduct, disruptive behavior, creating a nuisance by noise, or the use of obscene or foul language.

A condition of your entry to the programme will have been a satisfactory Certificate of Morality. Without confirmation that a satisfactory Certificate of Morality has been received, you will **not** be able to access practice placements.

It is important that you inform the School through your personal tutor or the VPA and at the earliest opportunity, if there are any events that may impact on the status of your criminal record, for example, if you receive any cautions by police, if you are charged by the police, prosecuted or/and convicted of any crime. Such events do not necessarily prevent you from continuing and completing your programme of study however, they may constitute non academic misconduct and/or, in situations where the outcome is pending, you may not be permitted to access practice placements until the outcome is known.

On an annual basis you are required to sign a declaration that you continue to be of good health and of good character. Good character will include a declaration that there are no changes to your criminal record since the last Certificate of Morality check was undertaken.

5 Discipline and Due Process

5.1 Disciplinary Actions

Disciplinary actions normally occur in response to a violation of a school or hospital rule or policy. The general administration of the disciplinary program is the responsibility of the Admissions, Promotions, and Academic Standards (APAS) Committee. This committee oversees the disciplinary process for academic and non-academic matters.

Actions taken as a result of a specific situation are determined by:

- the details of the situation
- the seriousness of the violation, and
- the academic status and prior disciplinary history of the individual student or students involved.

The APAS committee may use *any* action(s) it considers appropriate in response to a violation. The above non-inclusive list is for illustration only; other actions may be implemented by the APAS committee. The list does not represent a step process (i.e., there is no obligation to begin with a written warning and proceed step-by-step through the actions in order); however the list is in relative order of seriousness in terms of potential impact on the student:

5.2 Written Warning. A written warning serves to notify a student that his/her behavior unacceptable. Normally results from report of violation by school or hospital personnel.

5.3 Disciplinary Probation. A student is placed on Disciplinary Probation due to an unacceptable behavior. Probation is for a specific length of time - up to the remainder of academic enrollment. Probation may include additional loss of privileges and is designed to prevent continued violations.

5.4 Suspension from the Program. A student is suspended for conduct or behavior that results in unethical, immoral, illegal or unsafe actions or violations of any school policy. A student can apply for readmission; however, appearance before the APAS Committee is required as part of the readmission process.

5.5 Dismissal from the Program. Dismissal from the program is the removal of a student from enrollment for a serious violation or continued failure to comply with school policies. Having been dismissed, the student is not eligible to apply for readmission.

5.6 Due Process. Due Process Rights and Appeals Procedure provide a fair method to resolve conflicts between parties and protect students from arbitrary, discriminatory, or unreasonable enforcement of school policies or actions.

○ **Due Process Rights**

The following listed rights are to insure that administrative proceedings, which involve disciplinary actions and/or grievances, are conducted in a fair and consistent manner. Each student involved in a disciplinary situation or who has a grievance has the right to:

1. File a written grievance or appeal.
2. Receive a written statement of charges and their basis, when applicable.
3. Know the nature of evidence/information being considered.
4. Present supporting evidence on his/her own behalf.
5. Request a personal appearance before the person or group.
6. Receive a timely response to the appeal or grievance.

○ **Grievance Process**

A grievance is any dissatisfaction, complaint or alleged injustice that results from an academic or non-academic experience with administrators, faculty/staff members, students.

○ **Basis For Making an Appeal**

It is the responsibility of the person making the appeal to demonstrate the validity of his/her reason for the appeal. A student has the right to appeal any action, based on one of the situations listed below:

1. The action taken is more severe than warranted based on the original situation.
2. New information was not available at the original decision.
3. Improper procedures, which altered the original decision.
4. Probable bias on the part of the decision-maker.

○ **Potential Results of an Appeal**

At each step of the appeals process, the *written appeal* will provide the basis for investigation of the appeal. However, as part of

deliberation or investigation, the appearance of some or all of the individuals involved may be requested. A written response to appeals at each level will be provided to the person appealing the decision. The possible results of an appeal are, that the original decision will be:

1. Upheld without change.
2. Increased in severity.
3. Modified in some way.
4. Completely rescinded.

o **General Process For Making An Appeal**

Written grievances must be submitted in person **within five working days** of the occurrence /decision to be considered. The student must initiate a meeting with the person(s) (student, committee or school/staff) directly involved in the occurrence or decision giving rise to the grievance and must attempt to resolve the problem with such person(s). (annexe)

5.6.1 Course Audit During Appeal Process. While awaiting the outcome of the appeal process, a student has the opportunity to request to audit the currently enrolled course OR the next consecutive course, if appeal occurs at the conclusion of the course. **Auditing the course** refers to attending lecture only. The student cannot participate in clinical experience or take examinations/quizzes for theory. Request to audit the course must be approved by the General Manager. All clinical hours and tests must be made up if the resolution of the appeal is to continue in the program.

6 Non-Discrimination Statement

A separate process governs situations where an individual feels he/she has been discriminated against on the basis of race, color, religion, age, sex, marital status, national or ethnic origin, or disability in the administration of the school's educational policies, scholarship and loan program, and athletic or other school-administered programs. If an individual believes that he/she has

been subjected to such discrimination, he/she should contact the CEO.

- For Disciplinary cases that goes to the University of Mauritius Disciplinary Committee, a fee of MUR 6,000 to MUR 15,000 must be paid by the student/ case, as regulated by the Code of Discipline of the University of Mauritius

Chapter VI: Uniform & Dress Code

I. GENERAL PROVISIONS

1. Statement of Purpose

The clothing and personal appearance of students can impact on the public perception of the quality of services in school, in clinical placement and outside the school.

Our Uniform and Dress Code policy is designed to:

- Ensure the personal appearance of our students contributes to a positive, professional image and promotes confidence in the professionals they will become.
- Promote patient safety and the prevention and control of infection by ensuring that all students wear clothing that is appropriate during their clinical placement.

During clinical placement at Apollo Bramwell Hospital, Apollo Bramwell Nursing School student nurses will respect the ABH Uniform and Dress Code Policy as follows:

"We are committed to reducing the number of avoidable infections in Apollo Bramwell Hospital to give confidence to patients and their families by taking action that the public sees. The attitude and actions of every individual can make a difference and the objectives our Uniform and Dress Code policy are to ensure that all staff:

- Understand what they should be doing and why;
- Contribute to good infection control practice;
- Lead by example;

- Reassure others that we provide a professional service and that patient safety and infection prevention and control are of the highest priority.

2. Uniform Allowance

Students are given **two sets of uniforms for school per year. Extra sets can be ordered or purchased by the student.** Three sets of uniforms and one pair of shoes for clinical placement are likewise given before their first clinical placement. They must ensure that they are wearing the appropriate and complete uniform every time.

II. At school

1. Definition of the Non-Clinical Area

For the purpose of the Uniform and Dress Code policy, a “school area” is defined as any area wherever the students wear the ABNS uniform (school, bus, street, hospital, etc.).

2. Identification

Each student needs to present either his/her Access Card with a visible photo identity with name and position details clearly displayed at all times.

3. General Presentation and Appearance

3.1 Students should always maintain a professional image.

3.2 Students should look clean and tidy, and have a good standard of personal hygiene.

- Clothes should be free from obvious dirt and stains.
- Hair should be clean and tidy. For ladies, hair that falls below the collar should be secured away from the face in a style that does not need constant re-adjusting. For males, hair need to be short and good appearance, facial hair **must** be kept short, neatly trimmed and tidy.
- Make up should be discreet.
- Tattoos, if any, should not be visible.

- Nails should be clean and well manicured. Nails must be short and unvarnished. False nails are not permitted as they support fungal growth.
- Males must ensure that their underpants are tucked in properly.

4. Jewellery

- 4.1 No visible body piercing;
- 4.2 No more than one discreet nose stud;
- 4.3 No tongue studs permitted

5. School Uniform

ABNS provides a uniform and this uniform must be worn at all times by the students. The uniform must be adhered to and not be altered in anyway. Should replacement be necessary, students will have to pay for it.

5.1 Footwear for students should:

- 5.1.1 Be clean and in good repair, **black or navy blue** for both males and ladies;
- 5.1.2 Have covered toe, soft sole. **flip-flops or other 'beach-style' footwear is not allowed.**
- 5.1.3 Have not heels higher than 2 cm; stiletto heels are **not allowed** for health and safety reasons.

5.2 Upon completion of/or discontinuation from the program, the student must ensure that their uniforms are destroyed to prevent their misuse which might bring the name of ABNS into disrepute.

III. The Clinical Area

1. Definition of the Clinical Area

For the purpose of the Uniform and Dress Code policy, a clinical area is defined as any area within the hospital where patients receive treatment and care. This includes, for example, Wards, Outpatient Department, Diagnostic Areas, Operating Theatres, Emergency Room/s and Ambulances.

2. Wearing of Prescribed Uniform

- 2.1 The student shall report to the assigned area in complete uniform.
- 2.1.1 The complete uniform for both men and women shall be:
- Prescribed white blouse/shirt with ABNS logo and white slacks/trousers
 - Prescribed shoes and socks
 - Access cards / nameplate
- 2.1.2 The following accessories must be in the student's possession while on duty: a watch with second hand, a bandage scissors, black and red pens, a stethoscope and a penlight.
- 2.2 Any missing item in the uniform, e.g. nameplate, shall be counted as one late.
- 2.3 Uniforms must not be worn outside of the hospital premises.
- 2.4 When traveling to and from their placement, students must wear the school uniform.
- 2.5 During pregnancy, a student may wear a white coat.

3. Grooming

- 3.1 The student shall report to the assigned area properly groomed.
- 3.2 Uniforms shall be clean and neatly pressed, shoes well polished.
- 3.3 Only white underwear shall be worn when on duty.
- 3.4 The following guidelines for the hair shall be observed:
- 3.4.1 Long hair shall be kept away from the face, tied to the back and worn in a bun; short hair should not touch the collar.
- 3.4.2 Only a simple black hair accessory may be used
- 3.4.3 Highlighting is not allowed for both male and female students.

- 3.5 For the female student only a minimum of day make-up is permissible
- 3.6 Use of jewelry while in clinical placement shall be minimized to a wedding ring, one pair of plain, discreet ear studs and/or one discreet nose stud.
- 3.7 Fingernails shall be kept short, clean and without nail polish at all times
- 3.8 The student should be conscious of his/her hygiene. He/She should smell fresh and clean. The use of deodorant is encouraged. However, strong smelling perfumes should be avoided.

4. Maintenance of/Replacement of Uniforms

- 4.1 Clinical uniforms worn by students will be laundered by ABH. Dirty Uniforms should not be taken home
- 4.2 Students are expected to promptly change out of their uniforms at the end of each shift before leaving their workplace. Dirty uniforms should be disposed of properly on the linen skip inside the lockers.
- 4.3 Shared changing facilities and lockers are provided in a designated area of the hospital for students' use. Locker rooms should be kept tidy at all times.
- 4.4 Students are expected to follow the routine frequency for change of uniform and the circumstances where the uniform should be substituted immediately (in the event of contamination with blood or body fluids).

5. Non-Compliance with Uniform & Dress Policy

- 5.1 Students are expected to comply with the dress code of the clinical facility to which they are assigned. Failure to do so will result in dismissal from that clinical setting for the day.
- 5.2 If students are considered inappropriately dressed they will be given a verbal warning and will be sent off duty. This will be reported as an absence until the student returns dressed appropriately. The time associated with these absences will need to be made up. Following this first verbal warning any

second incident of breach in following the uniform policy will be considered unprofessional conduct and as a result the student will normally face disciplinary action.

Chapter VII: Other Policies

1. Health Requirements for Level One

Prior to the first day of classes, all students must submit a current physical examination. The School Office maintains student health records as part of the student's official file. Students will be denied access to clinical laboratory experiences regarding direct patient care until all required health forms are accepted.

2. Pregnancy

A student who becomes pregnant may continue in the program with the consent of her private physician. A written statement from the physician indicating that the student may continue with no activity restrictions must be submitted within the first trimester of the pregnancy to be filed in the student's record. If a complication arises, a Medical Leave of Absence (MLOA) may be requested – see Medical Leave of Absence Procedure in Student Handbook. In addition, a written release from the physician must also be provided upon the student's return to school after delivery.

3. Accidents and Incidents

If you are involved in an accident/incident during your course, (whether or not you are injured), are a witness to one or have one reported to you, you must inform a member of staff as soon as possible.

If you are on placement, the accident/incident should be reported immediately to the manager of the area and subsequently you should notify your Personal Tutor and the Clinical Instructor for the area.

To comply with Health and Safety regulations, appropriate records should be maintained. **ALL** accidents/incidents that occur within ABNS site or while undertaking practice placement **MUST** be recorded using the official documents used in the area concerned. You may also be required to complete a school incident form.

4. Fire Safety

It is the responsibility of individual students to make themselves aware of the procedure to be followed in the event of fire. Instructions are displayed in prominent areas throughout University buildings.

At the beginning of each practice placement you will receive an orientation and induction that will include information and instructions relating to health and safety procedures that are specific to the area of practice.

Chapter VIII: FINANCIAL SERVICE INFORMATION

Tuition

All tuition and fees are due between 5th day of each month

Payment is defined as a receipt for payment in full, a financial aid award letter showing funds for the term equal to or greater than your charges for the term on your registration form, approval to bill a third party for the full payment due, or a signed payment plan from the Accounting Department. If tuition is not paid or arrangements have not been made, by the first day of classes, ABNS reserves the right to cancel the student's registration. A student may not register for classes or graduate if a balance exists on their student account. Academic Transcripts will not be released if a past due balance exists on a student's account.

ALL FEES SHOWN ABOVE ARE NON-REFUNDABLE

All students must comply with the rules and regulations of the fees and payments as stipulated in the student's contract.



Chapter I Vision and Mission Statements

1. Vision

The Apollo Bramwell Nursing School shall be the best nursing school in Mauritius and the region and shall become internationally recognized as a Center of Excellence in Nursing Education.

Program development will be geared towards research and evidence-based practice and forging strong academic exchanges with international universities of repute.

2. Mission

Our mission is to strive to provide the highest level of nursing instruction and develop parallel courses for a holistic approach to nursing education in order to produce highly qualified and specialized nursing officers of the highest standards who can become tomorrow's leaders in the field of nursing and research.

3. Philosophy

The philosophy of Apollo Bramwell Nursing School is embodied in the following statements:

Human beings are unique, rational individuals possessing self-worth and dignity, deserving recognition of essential qualities: intellectual, psychological, physical, spiritual and social. Human beings can utilize their potential for self-development and self-improvement. People are capable of modifying their environment and their responses to it.

The **Environment** covers all influences the individual's internal responses, beliefs, values and experiences. Environment includes influences of culture,

Clinical Element

- The hours of clinical contact per week will vary per academic year as below:
 - No. of hours per day: 8 - 12 hrs
 - No. of days of duty per week: 3 - 5 days
 - Total hours of clinical field experience per week: between 40 – 45 hrs

The distribution of hours per week below is a guide as this will vary from year to year depending upon the number of hours allocated for theory and clinical/field experience.

<u>Year</u>	<u>Weeks</u>	<u>Weeks x Hours x days per Week</u>	<u>Weeks x hours x days per week</u>
		<u>Theoretical Element (theory+lab)</u>	<u>Clinical Element</u>
<u>First</u>	<u>45</u>	<u>31 x 6.5 x 5 ~ 1000 hrs</u>	<u>11 x 8 x 5 +10 ~ 450 hrs</u>
<u>Second</u>	<u>45</u>	<u>41 x 6 x 3 ~ 740 hrs</u>	<u>43 x 8 x 2.5 ~ 810 hrs</u>
<u>Third</u>	<u>45</u>	<u>23 x 6 x 4 ~ 545 hrs</u>	<u>27 x 8 x 5 ~ 1080 hrs</u>
<u>TOTAL</u>	<u>135</u>	<u>Total hrs = 2285</u>	<u>Total hrs = 2340</u>
<u>Total Hours for the Programme = 4625</u>			

Standards

- The Diploma programme will be based on a modular CREDIT SYSTEM.
 - 15 hours of lectures will be equivalent to 1 credit.
 - 45 hours of laboratory practice will be equivalent to 1 credit
 - 90 hours of clinical placement will be equivalent to 1 credit.
- Proficiency in theory and clinical practice will be assessed by tutors/mentors/linked tutor after each semester/year and

NURS 2003	Psychosocial Context of Health and Illness II	30/45	3
NURS 2004	Medical and Surgical Nursing I	90/45	7
NURS 2005	Obstetric and Midwifery I	75/45	6
NURS 2006	Community Health Nursing II	15/20	1.5
NURS 2007	An Introduction to Research	20/50	2.5
NURS 2008	Nursing Management and Education II	30/45	3
NURS 2009	Specialized Nursing 1	60/45	5
NURS 2000	Clinical Placement II	810 Hrs	9
	Total	380 L, 360 P, 810 CP	42.5
YEAR 3			
NURS 3001	Research in Nursing	15/0	1
NURS 3002	Nursing Management and Education III	30/20	2.5
NURS 3003	Obstetric and Midwifery II	40/60	4
NURS 3004	Medical and Surgical Nursing II	40/80	4.5
NURS 3005	Specialized Nursing 1I	80/120	8
NURS 3006	Professional Project in Nursing	15/45	2
NURS 3000	Clinical Placement III	1080 Hrs	12
	Total	220 L, 325 P, 1080 CP	34
	GRAND TOTAL		130

7. Description of Modules

NURS 1001 - NURSING THEORY AND PRACTICE I

Introduction to Nursing: Supervised Clinical Observation; Nursing Science; Nursing care of the Patient / Client. Basic Nursing Care and Needs of the Patient.

First Aid: Introduction; Importance of first aid and rules of first aid; Concept of emergency. First Aid in Emergency situations. Community Emergencies and Resource Community Emergencies.

Personal Hygiene: Introduction: Concept of health and its relation to successful living. Maintenance of Health. Physical Health.

Nutrition: Introduction; Classification of food. Normal dietary requirements and deficiency diseases of each of the constituents of food. Preparation, Preservation and Storage of Food. Introduction to Diet Therapy. Community Nutrition. Common Preparations / Practicals.

NURS 1002 - LIFE SCIENCES FOR NURSING

Introduction to anatomical terms. Organization of body cells, tissues, organs, systems membranes and glands. Skeletal System. Muscular System. Cardiovascular System, Lymphatic System. Respiratory System. Digestive System. Urinary System. Nervous System. Endocrine System. Sense Organs. Reproductive System.

Microbiology: Introduction; Brief historical review of bacteriology and microbiology; Scope and usefulness of knowledge of microbiology in nursing. Micro-organisms. Infection and its transmission. Immunity. The control and destruction of micro-organisms. Introduction to Laboratory techniques.

NURS 1003 - PSYCHOSOCIAL CONTEXT OF HEALTH AND ILLNESS I

Psychology: Introduction; Definitions, scope of psychology and its importance in nursing profession. Psychology of Human Behaviours. Learning. Observation. Intelligence. Personality. Communication.

NURS 1004 - PHARMACOLOGY

Concept of pharmacology. Classification of drugs. Administration of drugs. General action of drugs.

NURS 1005 - MENTAL HEALTH NURSING

Introduction: Meaning of mental health and mental illness. History of Psychiatry. Mental Health Assessment. Community Mental Health. Psychiatric Nursing Management. Mental disorders and Nursing Interventions: Functional Mental disorders; Definition, etiology, signs, symptoms, medical and nursing management. Bio-Psychosocial Therapies: Psychopharmacology; Psychosocial therapies; Somatic therapy. Forensic Psychiatry/Legal Aspects. Psychiatric Emergencies and Crisis Intervention.

NURS 1006 - COMMUNITY HEALTH NURSING I

Introduction to Community Health and Community Health Nursing. Community Health Nursing Process.

Environmental Hygiene: Introduction. Environmental Factors Contributing to Health Water. Community Organization to Promote Environmental Health. Health care services in Mauritius. Health Planning in Mauritius.

Health Assessment. Principles of Epidemiology and Epidemiological Methods. Family Health Nursing Care. Family Health Care Settings. Referral Systems. Records and Reports. Minor Ailments.

NURS 1007 - COMMUNICATION SKILLS & INFORMATION TECHNOLOGY

Writing of report using appropriate English Language: Grammar/Vocabulary.

NURS 1008 - NURSING MANAGEMENT AND EDUCATION I

Professional Trends and Adjustments - Introduction to nursing as a profession. Professional ethics. Personal and professional growth/development: a) Continuing Education; b) Career in Nursing. Legislation in Nursing. Professional and related organizations.

NURS 2001 - NURSING THEORY AND PRACTICE II

Assessment of Patient/Client: Principles and importance of assessment, methods of assessment: observation, palpation, auscultation, percussion, developing skill in observation. Therapeutic Nursing Care and Procedures Asepsis. Basic Needs and Care in Special Conditions.

NURS 2002 - PHARMACOTHERAPY FOR NURSING

Nursing implications in administration of drugs.

NURS 2003 - PSYCHOSOCIAL CONTEXT OF HEALTH AND ILLNESS II

Sociology: Introduction. The Individual. The Family. The Society. The Community. Economy.

NURS 2004 - MEDICAL AND SURGICAL NURSING I

Introduction. Nursing Assessment. Patho-Physiological Mechanism of Disease. Altered Immune Response. Clinical Pharmacology. Nurse's role in Management of Fluid, Electrolyte and Acid Base Balance. Management of Patients in Pain. Operation Theatre Technique Physical Environment: Preparation of theater equipment & supplies. Management of Patient Undergoing Surgery: Nursing management of pre-operative patient; Intra Operative Management; Post-operative management - Immediate and Routine. Nursing Management of Patient with Impaired Respiratory Function and Gaseous Exchange. Nursing Management of Patients with Digestive and Gastro Intestinal Disorders. Nursing Management of Patients with Metabolic and Endocrine Disorders. Emergency Management, Nurse's role in emergency conditions. Medical surgical emergencies.

NURS 2005 - MIDWIFERY & OBSTETRICS I

History and broad perspective of obstetrics. Review of Anatomy and Physiology of female reproductive system. Embryology. Pregnancy. Normal Labour. Normal Puerperium. Neo Natal Disorders.

NURS 2006 - COMMUNITY HEALTH NURSING II

Specialized community health services and nurse's role. Nurse's role in National Health Programmes. Demography and Family Welfare Demography. Health Team: Concept, Composition, Functions. Role of nursing personnel at various levels. Vital Health Statistics.

NURS 2007 - AN INTRODUCTION TO RESEARCH

Introduction to research process. Introduction to research approaches for nursing.

NURS 2008 - NURSING MANAGEMENT AND EDUCATION II

Administration and Ward Management - Introduction. Planning: Aims, Principle, Methods and Types. Organization: Command, Co-ordination and Control, Delegation. Staffing and Budgeting.

NURS 2009 - SPECIALISED NURSING I

AIDS (Acquired Immunodeficiency Syndrome) - Review the anatomy and physiology of the lymphatic and immune system. The pathogenesis of the HIVirus and its effect on health. Modes of transmission: Prevention Strategies at International, National and individual level. The epidemiology of HIV/AIDS and factors fuelling the epidemic. Opportunistic infection and Antiretroviral treatment. HIV Counselling and Testing. Psychosocial aspect of HIV/AIDS, Stigma and Discrimination. Standard Precautions and HIV Post Exposure Prophylaxis. Legal and Ethical issues in HIV.

Paediatric Nursing - Introduction: Concept in child health care; Trends in paediatric nursing; Role of paediatric nurse in child care. The Newborn. The Healthy Child. The Sick Child. Behavioural Disorders and common Health Problems. Children with congenital Defects/Malformations. Children with various disorders and diseases. Welfare of Children.

DIABETES MELLITUS - Type 1 and type 2 diabetes; key educational issues associated with each therapeutic agent; important educational areas in teaching self glucose monitoring and demonstration of a glucose measurement method; identification, treatment and prevention of hypoglycemia and hyperglycemia; essential components of a diabetes care plan and billing methods for nursing care of patients with diabetes; proper technique for drawing and injecting insulin; regulations-based whole blood technology testing and screening procedure; nutritional recommendations of the Diabetes Association; importance of patient education issues related to diabetes and

exercise, illness and hypoglycemia; emotional, social and financial barriers to adherence with diabetes.

NURS 3001 - RESEARCH IN NURSING

Research in nursing, link with professional project for future nurses.

NURS 3002 - NURSING MANAGEMENT AND EDUCATION III

Health Education/Teaching in Clinical Setting - Introduction. Methods and Medium of Health Education. Health Education Agencies.

NURS 3003 - MIDWIFERY & OBSTETRICS II

High risks pregnancy. Post Partum. Complications in Pregnancy. Induction of labour, Preterm labour and Post maturity: Abnormalities of Labour; Abnormalities of puerperium; Obstetrical emergencies and operative obstetrics; Special cases.

NURS 3004 - MEDICAL AND SURGICAL NURSING II

Nursing Management of Patients with Renal and Urinary Disorders. Nursing Management of Patients with Neurological Disorders. Nursing Management of Patients with Disorders of Connective Tissue and Collagen Disorders. Nursing Management of the Elderly.

NURS 3005 - SPECIALISED NURSING II

Ophthalmology - Assessment of function of eyes. Diseases and disorders of eyes and their management.

Otorhinolaryngology (Disorders of ear, nose, throat) - Assessment of the function of Ear, Nose and Throat. Disorders and diseases of the Ear, Nose and Throat. Disorders of nose, Paranasal Sinuses, Throat and adenoids. Surgery and Nursing care. Dietetics: Diet in ENT diseases.

Cardiology - Nursing Management of Patients with Cardio-Vascular Circulatory and Haematological Disorders. Assessment of cardio-vascular functions. Management of patients with cardio-vascular diseases. Sample and request for blood transfusion. Safety checks and records for blood transfusion.

Burns - Definition and types of burns. Causes of burns. First Aid measures. Management of a patient with Burns. Accident & Emergency dept. General and specific Nursing care.

Oncology - Introduction. Nursing management of patient receiving oncologic treatment.

Plastic/Reconstructive Surgery - Types. Nursing implications in preparing patient for plastic/ reconstructive surgery.

Nephrology - Review of Anatomy and Physiology of renal system: Medicine; Surgery; Renal Nursing.

NURS 3006 - PROFESSIONAL PROJECT IN NURSING

Definition of professional project in nursing. Personal training and counseling about the professional project.

8. Non-discrimination statement

Apollo Bramwell Nursing School does not discriminate on the basis of race, color, religion, age, sex, marital status, national or ethnic origin, or disability in the administration of its educational policies, scholarship or other school administered programs.

If individuals believe that they have been subjected to such discrimination, they should contact the CEO.

9. Educational Policy

When an applicant is admitted to the Apollo Bramwell Nursing School, he/she is subject to all policies and procedures of the school. Admission to the school carries no assurance of promotion, graduation, or awarding of a diploma. Continuation as a student, promotion, and eventual graduation are dependent on the fulfillment of all academic requirements and compliance with all policies and procedures of the school. Failure to comply with these requirements may result adverse consequences, up to and including dismissal. If the student is dismissed, no assurance is given that he/she will be readmitted.

10. Changes to Policies and Procedures

All policies, procedures, requirements, and costs shown in this handbook are subject to change without prior notification. Students should check both their individual e-mailboxes and the official bulletin boards regularly for the most accurate and up to date information. All reasonable actions will be taken to inform students of changes to policies, procedures, and costs prior to the actual effective change.

NURS 2005 - MIDWIFERY & OBSTETRICS I

History and broad perspective of obstetrics. Review of Anatomy and Physiology of female reproductive system. Embryology. Pregnancy. Normal Labour. Normal Puerperium. Neo Natal Disorders.

exercise, illness and hypoglycemia; emotional, social and financial barriers to adherence with diabetes.

NURS 3001 - RESEARCH IN NURSING

Research in nursing, link with professional project for future nurses.

NURS 3002 - NURSING MANAGEMENT AND EDUCATION III

Health Education/Teaching in Clinical Setting - Introduction. Methods and Medium of Health Education. Health Education Agencies.

NURS 3003 - MIDWIFERY & OBSTETRICS II

High risks pregnancy. Post Partum. Complications in Pregnancy. Induction of labour, Preterm labour and Post maturity: Abnormalities of Labour; Abnormalities of puerperium; Obstetrical emergencies and operative obstetrics; Special cases.

NURS 3004 - MEDICAL AND SURGICAL NURSING II

Nursing Management of Patients with Renal and Urinary Disorders. Nursing Management of Patients with Neurological Disorders. Nursing Management of Patients with Disorders of Connective Tissue and Collagen Disorders. Nursing Management of the Elderly.

NURS 3005 - SPECIALISED NURSING II

Ophthalmology - Assessment of function of eyes. Diseases and disorders of eyes and their management.

Otorhinolaryngology (Disorders of ear, nose, throat) - Assessment of the function of Ear, Nose and Throat. Disorders and diseases of the Ear, Nose and Throat. Disorders of nose, Paranasal Sinuses, Throat and adenoids. Surgery and Nursing care. Dietetics: Diet in ENT diseases.

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**APOLLO BRAMWELL
NURSING SCHOOL**

STUDENT HANDBOOK

Name ABOO-B.S. FATALLY

Describe the body region each of these terms refer to:

1. Abdominal	abdomen which is inferior to the shoulders
2. Acromial	refers to the part of the scapula attached to clavicle
3. Antebrachial	refers to the antebrachium between brachium & hand
4. Brachial	refers to the arm
5. Buccal	refers to the mouth which is anterior to the spine.
6. Carpal	refers to the joints of the fingers distal to the wrist - coronal
7. Celiac	refers to the celiac artery, refers to the hand -
8. Cephalic	refers to the head
9. Cervical	refers to the neck as in the cervical vertebrae.
10. Costal	refers to the
11. Coxal	refers to the coxyle
12. Digital	refers to the fingers
13. Dorsal	is used with ventral to describe using coronal plane
14. Femoral	refers to the bone femur in the thigh.
15. Frontal	refers to the head as opposed to occipital
16. Genital	refers to the genitalia, the
17. Gluteal	refers to the gluteus maximus, minimus muscle.
18. Inguinal	refers to the part between the femur & pubis bones
19. Lumbar	refers to the vertebrae superior to the lumbax
20. Mammary	refers to the glands on the chest inferior to the upper quadrant
21. Nasal	refers to the nose, midline on the face.
22. Occipital	refers to the back of the skull posteriorly.
23. Oral	refers to the mouth which is inferior to the nose
24. Orbital	refers to the orbits of the skull lateral to the nose
25. Otic	refers to the ears
26. Palmar	refers to the palm of the hand.
27. Pectoral	refers to the chest, anteriorly
28. Pedal	refers to the feet which is distal to the knee cap
29. Pelvic	refers to the pelvis, bones that support the abdomen
30. Sacral	refers to the sacrum
31. Sternal	refers to the sternum on the midline
32. Umbilical	refers to the umbilicus
33. Vertebral	refers to the vertebrae

The brachium is between the upper segment of the arm from the shoulder to the elbow.

NURS1002

2404

2014

0810

208

ABNS 1405011

INTRODUCTION

To

ANATOMY & Physiology

Intro duct to-day at-

Cells to-nann-

Sagittal plane - Lf & Rt - mid sagittal

Word

axial

Systems: Skeletal ①

Digestive ②

Nervous ③ Endocrine

Muscular ④

Respiratory ⑤

⑥

ML

medial lateral
medial
lateral & histol

BRYA

Science

Na⁺

K⁺

Ions

Directional
Terminology

IS
ML

PD

AP

axis

Geometry

Procedural

① Positive Feedback loop mechanisms # 1: delivery

2: lactation

3: clotting factors 12 or

② Negative Feedback loop mechanisms # eating, Height.

Breathing - Running -

adrenaline -

Insulin -

#

Homeostasis - positive goes beyond limit

negative do not over -!

0840

Semester 1

YEAR 1

NUTS1002

2404

2014

0913

appendix is part of lymphatics

abdominal organs - from small to large intestine

16th 20/10/20 - 20

11/10/20 120 days 5/10/20

Pancreas - liver
kidney
pancreas
adrenal glands
liver
adrenal - pancreas

RT u Q

Stomach, spleen - body, plant

adrenal
major part of kidney
pancreas
liver
descent
colon

Lf up Q

Substernal pain

Sigmoid

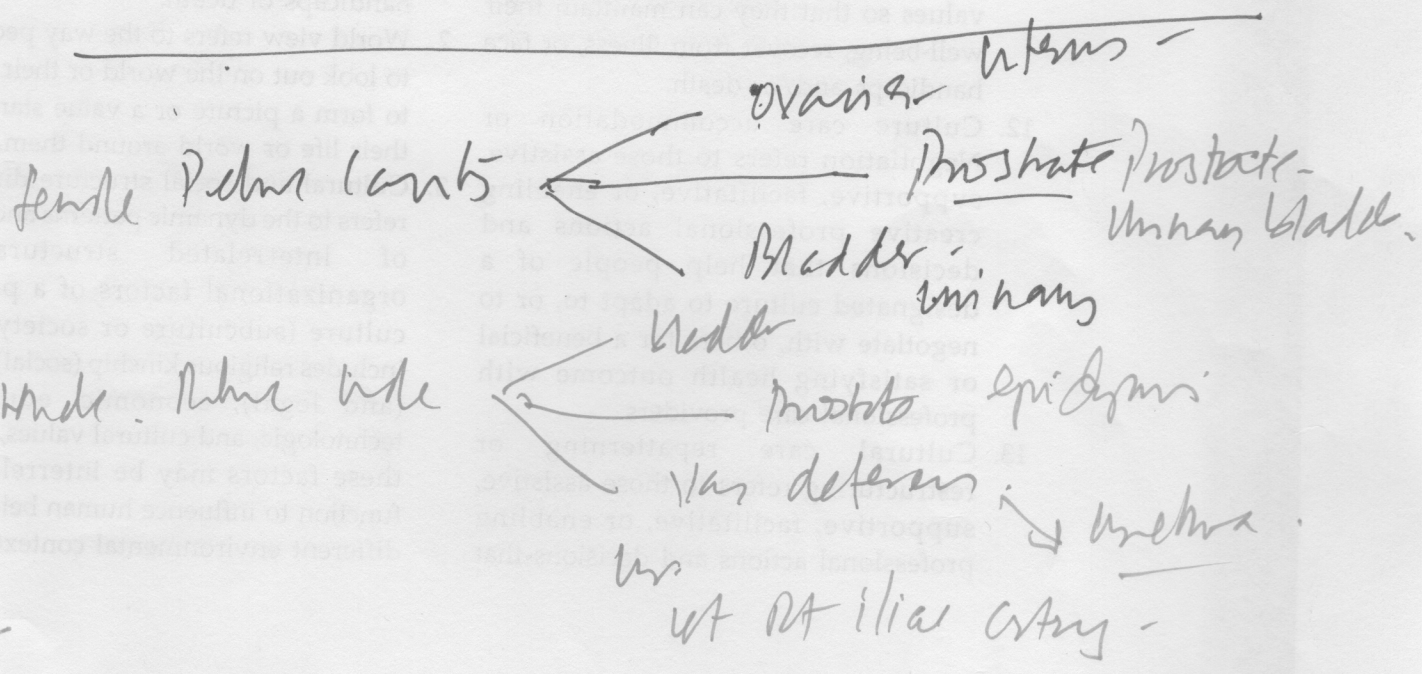
NWPS 1002

2404
2014

What makes up a cavity?

- Anterior
- 2 1 VENTRAL Cavities
- a Thoracic cavity
 - b abdominal cavity
 - c pelvic cavity

- Posterior
- 2 Dorsal Cavities
- 1 Cranial -
- mediastinum
H, esoph - Bronchi



1015

2404
2014

Serous membranes -

- > line the trunk cavities and
- cover the trunk cavities
- > fluids -

taxonomy

Visceral → Deep part } Layer

Parietal → upper /

- Peritoneum - pleura - fluid -

> Serous membranes secrete

fluids that fill the space between them.

parietal and visceral membranes.
fluid.

Visceral

Whorls

parietal.

negative pressure -

1027

2 layers -

Parietal

Visceral

} Such a.

Size

Peritoneum - /

Ogallan
in peritoneal

calcity

Pleural tapping

1034

Semester 1

- Leave sharp in puncture wound =

leave
healed

lung collapse

Suchin

negative
pressure
mainly

- pressure

YEAR 1

NURS1002.

ABNS 1405011

BONYA.

2404

(Ana-landia (PR.) ^{AAA} AHCatarrh
Cheetz mammal (CPA)

2014

12 par, 2 floats, 2 - not attached -
8 fine wls - 4 tube - 2 flw - 214

Rt upper

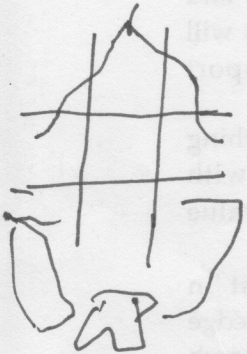
RT
Hypothor
PMAC

Epigastria

Rehrens

it
Hypothor
modria

4
Rt upper.



Lumbar

umbil
LILAL

Lumbar

RT
Iliac

Hypothor
bASTIC

Lt
Iliac

Anahtans

LF P

Rt lower

lower
anah

Rt upper
Quadrant

index.
Rt and left transfer
anah.

Left upper
Q

Stomach -
lower.

LUO

falling
Rt
lower Quadrant

Lt lower
Quadrant

abdominal region

4 quadrants

9 regions.

4
9

Semester 1

Exam 1

NURS1002

ABNS 1405011

Rep

1302Y1A

2404
2014

INTRODUCTION Anatomy in 18th
J. DeBordenent - mechanical Scalpel.
- chemical -
- ankytic dressing.

18th

regulate 1, longitudinal based on longest axis

GIRDLES
Girdles

transverse

Oblique

axial

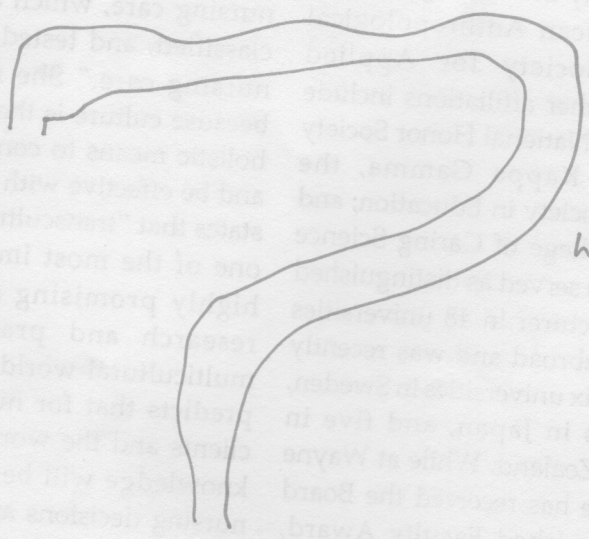
where hum
are
attached at
the
attachment

LONGITUDINAL

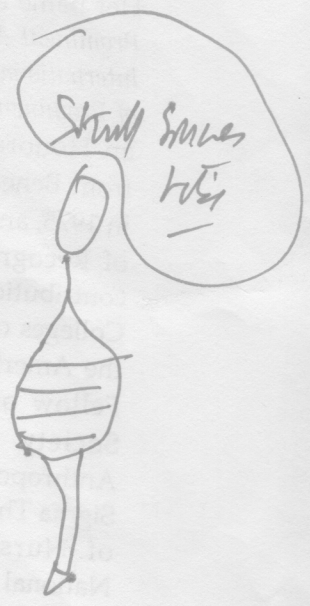
longitudinal

capitals - most
8 caps bones

limbs
axial



vertebrae



trans

oblique

a axial region -
limits of
head, neck, and
trunk.

NVR 9/102

ABN 5/1405011

BORNT.

2404
2014

Tibia	Catamen
Femur -	(8) Capital
Patella -	(8)
Pelvic Bone	Tarsal 8 bones.
Femur -	Metatarsals -
Pelvic Bone	=

134
=

axial legum - appendicular -
bones are attachment points

AXIAL BONES.

Cranial, Vertebrae, Cervical, Sacral, Sternum,
occipital - frontal, parietal, temporal, occipital,
Sphenoid, temporal - occipital -
Mandible, maxilla, axis, atlas - II =
frontal - occipital - temporal - parietal - petrous.
Mandible, maxilla - Vertebrae, 1. ~~over~~ atlas,

7.	Cervical	bones =	12
			2 (hook) etc
12	Dorsal	bones -	7 attached to Sternum.
6	Lumbar	bones =	
			CPR -
1	Sacral -	Super -	Landmark A
			Anatomical Landmark for CPR -
			LANDMARK.

0001

Semester 2

YEAR 4

NUTS1002

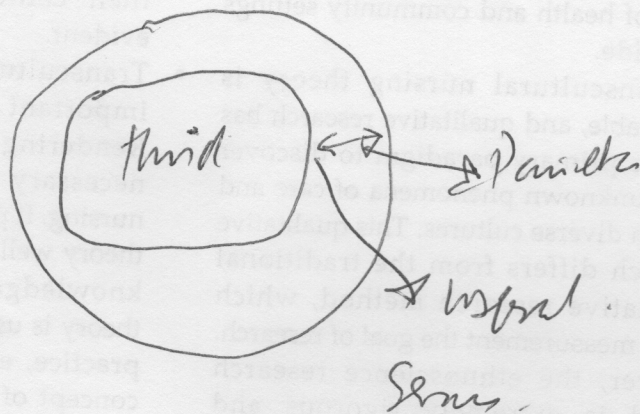
ABAS 1405014

BRYA.

2014
2404.

Heart Pericardium $\left\{ \begin{array}{l} \text{Visceral} \\ \text{Parietal} \end{array} \right.$ Epide - Reactive

Cavities $\left\{ \begin{array}{l} \text{Visceral} \\ \text{Parietal} \end{array} \right.$ area



Physia

Cells
organelles

cellular
membrane

Cellular

Division

Intobion

metabolism

transport

protection

control -
permeability

osmosis

osmosis

TERMINOLOGY AND BODY ORGANIZATION

The body has a ventral cavity, consisting of several subdivisions and containing the internal organs collectively referred to as the VISCERA. Other minor cavities include nasal, oral (buccal) orbital, middle ear, synovial). Older texts may discuss a dorsal body cavity consisting of cranial and spinal cavities.

Using your text as a reference, name the subdivisions of the ventral cavity that the following organs are located in:

Stomach: The Abdominal cavity

Liver: The Abdominal cavity

Lungs: The Thoracic cavity

Urinary bladder: The Pelvic cavity

Pancreas: The abdominal cavity.

Spleen: The abdominal cavity.

Esophagus: The Thoracic cavity

The lungs: The Thoracic cavity

adrenal glands: The Abdominal cavity

20/04

2404 Systems: List a function of each system below and examples of organs or structures in each.

- 1: circulatory: transports nutrients to cells
- 2: digestive: breaks down food into peptide, polypeptide, amino acids, sugars.
- 3: endocrine: releases proteins, fluids that target organs such as hormones release
- 4: Skeletal: manufactures erythrocytes
- 5: muscular: moves bones
- 6: reproductive: replicate the species.
- 7: Integumentary: protect the other systems.
- 8: nervous system: handles coordination, orientation in space, and time.
- 9: Respiratory system: supplies the cells with oxygen and removes carbon dioxide.
- 10: Urinary system: removes excess fluids, and salts.
- 11: lymphatic: protects the organs from invading pathogens.

Levels of Organization :

A portion of the level of organization of the body, as presented in the text consists of the cell, tissue, and organ levels. Given the following, classify each into the correct level.

Stomach is an organ.

Muscle is a tissue.

Brain is an organ.

Skin is an organ.

Cartilage is a tissue.

Pancreas is an organ.

Neuron is a cell.

Epithelium is a tissue.

Thyroid gland is an organ.

Bone is a tissue.

Blood is a tissue.

Leukocyte is a cell.

Nurs1002

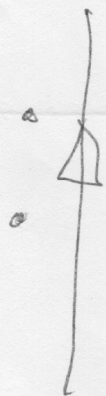
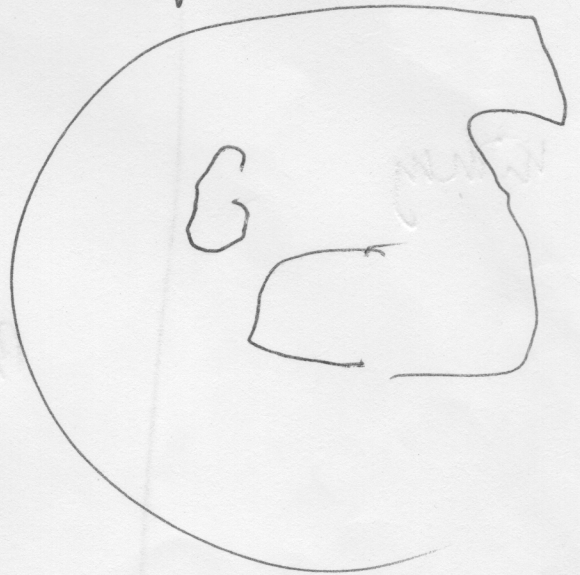
Exercise 2. Name a plane of reference that would pass ^{BRNA} through both structures (more than one answer may be possible for some of them).

Planes of Reference ~~that would~~: [Median (midsagittal), Sagittal, parasagittal, frontal (coronal), transverse (cross section).

A: patella is parasagittal to the sternum.

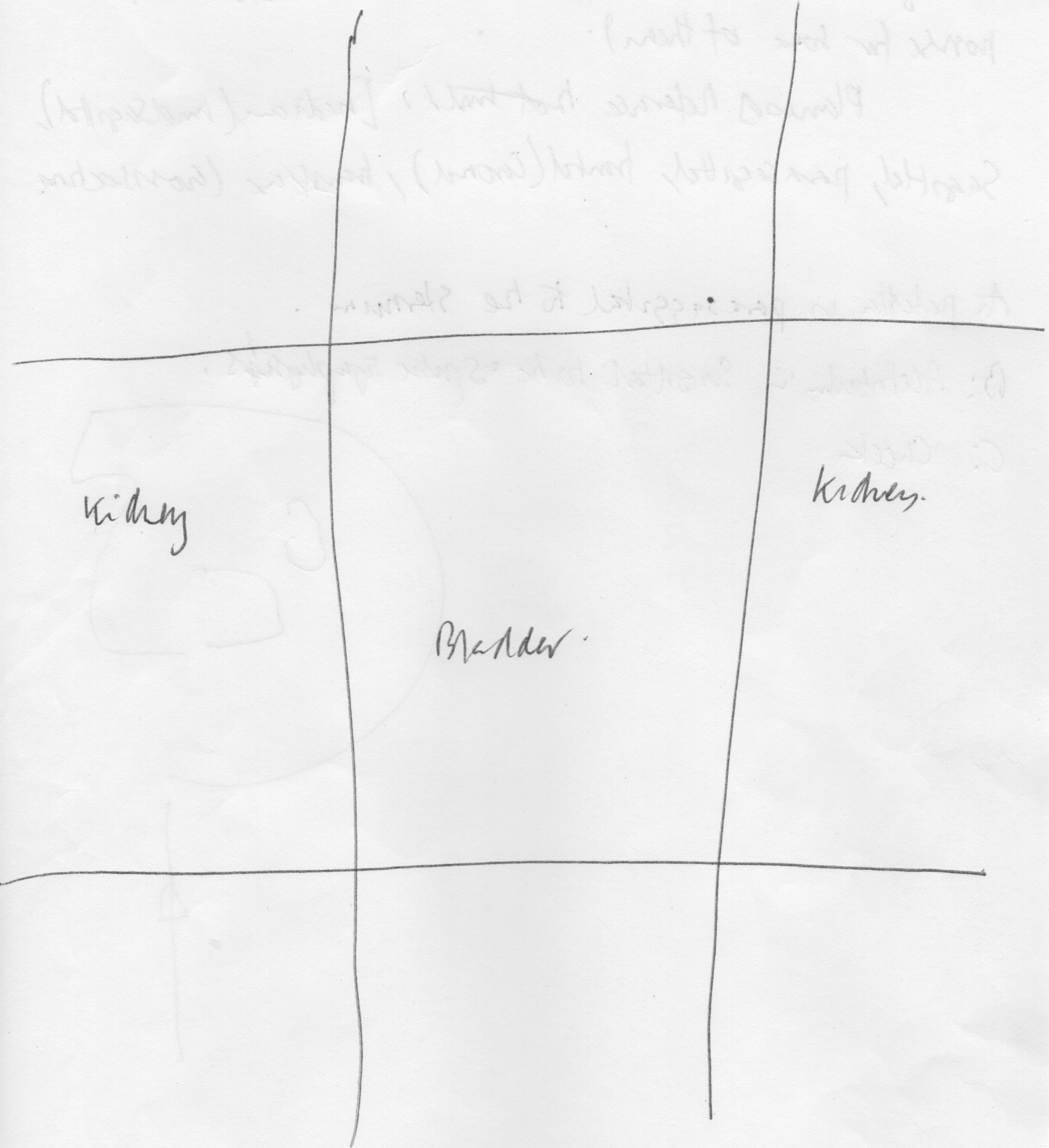
B: Acetabulum is sagittal to the ischial epiphysis.

C: Cheek



Semester 2

ABDOMINAL PELVIC REGION & Outlet



Anatomical Directional Terminology:

For each of the following relationship (A-H),
perform exercises 1 and 2.

Exercise 1: Use the directional term to describe
the relationship of the structures as listed.

Directional terms: Superior, inferior, dorsal, ventral,

proximal, distal; medial, lateral.

A: patella (kneecap) is inferior to the sternum.

B: acetabulum (hip socket) is lateral to the pubic symphysis.

C: Cheek is ^{dorsal} inferior to the ear.

D: ankle is distal to the shin.

E: Elbow is proximal to the wrist.

F: vertebral column is dorsal to the umbilicus.

G: chin (mental region) is inferior to the forehead.

Horizontal region

H: hipbone is medial to the scapula.



Chapter I Vision and Mission Statements

1. Vision

The Apollo Bramwell Nursing School shall be the best nursing school in Mauritius and the region and shall become internationally recognized as a Center of Excellence in Nursing Education.

Program development will be geared towards research and evidence-based practice and forging strong academic exchanges with international universities of repute.

2. Mission

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Group Presentation Rubric

Module: _____

Topic: _____

Date: _____

Parameters	Criteria				Total	Remarks
	16-20	11-15	6-10	1-5		
Content/Knowledge - refers to the relevance of the information presented and the mastery of the topic	The data presented were of great relevance to the topic assigned and were enough to meet the objectives. Showed excellent mastery of the topic with enough examples, applications and implications.	Great deals of informations were presented but not enough to meet the objectives. Showed minimal mastery of the data with less examples, applications and implications.	The data showed minimal relevance to the topic assigned with less attainment of the objectives. No mastery of the topic with superficial applications and implications.	No relevance to the topic assigned. Poor knowledge of the topic with no examples, applications and implications.	$\frac{\quad}{20} \times 100$ $= \frac{\quad}{\quad} \times 50\%$	
Organization - refers to how the members organized the presentation for the audience to follow	The informations were presented logically with clear transition from one concept to another. No interruptions during the presentation.	The topics were presented logically with clear transition from one concept to another. However, minimal interruptions were noted during the presentation.	The topics were presented with less organization and notable difficulty in moving from one to concept to another. There were several interruptions during the presentation.	No organization was noted throughout the presentation. Informations were scattered from one concept to another.	$\frac{\quad}{20} \times 100$ $= \frac{\quad}{\quad} \times 30\%$	
Presentation - refers to the creativity, resourcefulness and time management.	Utilized appropriate visual materials showing creativity and involved the audience during the presentation.	Utilized appropriate visual aids with less creativity and minimal participation from the audience. Finished the	Utilized a simple routine visual aids showing lack of creativity with minimal to almost no audience	No creativity during the presentation. No audience participation. Failed to finished the presentation on time.	$\frac{\quad}{20} \times 100$ $= \frac{\quad}{\quad} \times 20\%$	

	Finished the presentation with the allotted time.	presentation on time.	participation. Failed to finish the presentation on time.			
					Sum total: _____	

1994

Apr - Monday 7th		Apr - Tuesday 8th		Apr - Wednesday 9th		Apr - Thursday 10th		Apr - Friday 11th	
am	pm	am	pm	am	pm	am	pm	am	pm

10

Apr - Monday 14th		Apr - Tuesday 15th		Apr - Wednesday 16th		Apr - Thursday 17th		Apr - Friday 18th	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00	1:00 - 5:00	8:00 - 12:00	1:00 - 5:00	8:00 - 12:00	1:00 - 5:00	8:00 - 12:00	1:00 - 5:00	8:00 - 12:00	1:00 - 5:00
Nurs1001	Nurs1001	Nurs1001	Nurs1001	Nurs1001	Nurs1001	Nurs1002	Nurs1003	Nurs1002	Nurs1003
BD Gurech	BD Gurech	BD Gurech	BD Gurech	BD Gurech	BD Gurech	BD Dugoro	BD Dugoro	BD Dugoro	BD Dugoro

1990

Apr - Monday 31st			Apr - Tuesday 22nd			Apr - Wednesday 13rd			Apr - Thursday 24th			Apr - Friday 25th		
am	pm		am	pm		am	pm		am	pm		am	pm	
8:00 - 12:00			8:00 - 12:00			8:00 - 12:00			8:00 - 12:00			8:00 - 12:00		
Nurs1001			Nurs1001			Nurs1001			Nurs 1002			Nurs 1002		
BM Degorio NF Mierres			BM Degorio			BM Degorio NF Mierres			BM Degorio	C Atchard		BM Degorio		

建興

Apr - Monday 2nd		Apr - Tuesday - 2nd		Apr - Wednesday 3rd		May - Thursday 1st		May - Friday 2nd	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00		8:00 - 12:00		8:00 - 12:00				8:00 - 12:00	1:00 - 3:00
Music1001		Music1001		Music1001				Nurs 1002	Nurs 1002
Anderson		A Nurbro		A Nurbro		LABOR DAY Bank Holiday		BM Degorio	

TIMETABLE FOR APRIL 2014 - BATCH 5

Week 2

Apr - Monday 7th		Apr - Tuesday - 8th		Apr - Wednesday 9th		Apr - Thursday 10th		Apr - Friday 11th	
am	pm	am	pm	am	pm	am	pm	am	pm

Week 3

Apr - Monday 14th		Apr - Tuesday - 15th		Apr - Wednesday 16th		Apr - Thursday 17th		Apr - Friday 18th	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:30 - 4:00
Nurs1001 BD Gunesh	Nurs 1007 C Aubdool	Nurs1001 BD Gunesh	Nurs 1003 C Aubdool	Nurs1001 BD Gunesh MFD Nierras	Nurs 1008 CJ Seegolam	Nurs 1002 BM Degorio	Nurs 1003 C Aubdool	Nurs 1002 BM Degorio	Nurs 1008 CJ Seegolam

Week 4

Apr - Monday 21st		Apr - Tuesday - 22nd		Apr - Wednesday 23rd		Apr - Thursday 24th		Apr - Friday 25th	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:30 - 3:00
Nurs1001 BM Degorio MF Nierras	Nurs 1007 C Aubdool	Nurs1001 BM Degorio	Nurs 1003 C Aubdool	Nurs1001 BM Degorio MF Nierras	Nurs 1008 CJ Seegolam	Nurs 1002 BM Degorio	Nurs 1003 C Aubdool	Nurs 1002 BM Degorio	Nurs 1008 CJ Seegolam

Week 5

Apr - Monday 28th		Apr - Tuesday - 29th		Apr - Wednesday 30th		May - Thursday 1st		May - Friday 2nd	
am	pm	am	pm	am	pm	am	pm	am	pm
8:00 - 12:00	1:00 - 3:00	8:00 - 12:00	1:00 - 3:30	8:00 - 12:00	1:00 - 3:30			8:00 - 12:00	1:30 - 3:00
Nurs1001 C Aubdool	Nurs 1007 C Aubdool	Nurs1001 A Nathoo	Nurs 1003 C Aubdool	Nurs1001 A Nathoo	Nurs 1008 CJ Seegolam	LABOR DAY Bank Holiday		Nurs 1002 BM Degorio	Nurs 1008 CJ Seegolam

[illegible][illegible]

Apollo Bramwell Nursing School
Apollo Bramwell Hospital, Moka

Nursing Theory and Practice I (NURS1001)
Course Plan

6 units lecture; 2 units' skills lab [90 hours lecture and 90 hours skills lab]

Batch 5

Week	Topics (Lecture/Demo)	Days 8 – 12am	# of Hours	Teacher	Skills Lab (Return Demo)	Days 8 – 12 am	# of Hours	Teacher
1 (14-16 April)	I. Overview of Nursing A: Nursing as an Art B: History of Nursing C. Scope of Nursing Practice D. Evolving Roles & Specialties	Monday Tuesday Wednesday	4 hours 4 hours 4 hours	Doy Doy Mae				
2 (21-23 April)	E. Nursing Theories	Tuesday	4 hours	Bryan	- History of Nursing Group/Role Play - Grp work: sharing of Insights - Integration/Case analysis	Mon Wed	4 2 2	Bryan Bryan/Mae
3 (28-30 April)	II. Health and Illness A: Concept of health, wellness and Illness B: Nature of Man C: Models of Health and Wellness D. Levels of Care	Monday Tuesday	4 hours 4 hours	Chottoo Alith	Unit Exam or Group Work? Presentations?	Wed	???	???
4 (05-07 May)	III: Concepts in Care of Patient /Clients A. Safety & Security B. Hygiene (with demo of Nursing procedures)	Monday Tuesday Wednesday	4 hours 8 hours	Feizal Alith				
5 (12-14 May)	Continue demo of hygiene procedures	Mon	4 hours	Alith	Bed making; giving a bed bath; shampooing; back massage; offering a urinal or bedpan Oral Hygiene, perennial, nail and foot care (practice time in lab)	Tue Wed	4 hours 4 hours	Cls / Tutors

Week	Topics (Lecture/Demo)	Days 8 – 12 am	# of Hours	Teacher	Skills Lab (Return Demo)	Days 8 – 12 am	# of Hours	Teacher
6 (19-21 May)	C. Homeostasis D. Vital Signs (w/ Demo on V/S taking	Mon / Tue	8 hours	Bryan	Vital signs taking	Wed	4 hours	Cls/Tutors
7 (26-28 May)	E. Rest & Sleep F. Infection Control	Monday Tues /Wed	4 hours 8 Hours	Feizal Feizal/Mo Babita				
8 (02-04 June)					Handwashing, PPE, (Practice) Return Demo (Assessed)	Mon Tue/Wed	4 hours 8 hours	
	CLINICAL PLACEMENT I (09 – 27 June 2014)							
9 30 Jun 01-02 July)	G. Nutrition	Mon - Tue	8 hours	Ilayavalli	Nutrition Screening: 24 hr /3 day recall; biceps mmt. (workshop) Nutritional Campaign - grpwork (poster/slide presentation) Height and weight-taking Feeding an adult	Wed	4 hours	Cls / Tutors
10 (07-09 July)	H. Urinary Elimination I. Bowel Elimination	Monday Tuesday	4 hours 4 hours	Alith Alith	Specimen Collection (urine/stools) Digital removal of Stools	Wed	4 hours	Cls / Tutors
11 (14-16 July)	J. Exercise & Mobility ➤ Maintaining good posture [standing,sitting,lying] ➤ Guidelines on Good Body Mechanics ➤ Ergonomic Hazards in the Workplace ➤ Positioning Clients ○ General Principles ○ Common positions ○ Use of positioning devices	Mon -Wed	12 hrs	Feizal/Mo Alith				

Week	Topics (Lecture/Demo)	Days 8 - 12 pm	# of Hours	Teacher	Skills Lab (Return Demo)	Days 8 - 12 am	# of Hours	Teacher
12 (21-23 Jul)	➤ Dangers of Inactivity/Benefits of Regular Exercise ➤ Turning, Moving & Transferring Clients ○ Use of Assistive Devices	Monday	4 hours	Feizal & Mo	Procedures: 1. Turning & Positioning a Client in Bed 2. Moving – up a Client in Bed 3. Transferring a Client from Bed to Wheelchair 4. Transferring a Client from Bed to Stretcher 5. Shifting and Lifting Clients	Tuesday Wed	8 hours	
13 (28-30 Jul)	Relevant Procedures for Meeting Clients Need for Activity/Exercise i. Performing Passive Range of Motion Exercises (PROM) ii. Assisting Clients do Passive and Active Exercises iii. Assisting with Ambulation ○ Assisting Clients with Ambulatory Aids	Monday Tuesday	8 hours	Bryan	1. PROM 2. Isometric Exercises 3. Passive and active Exercises 4. Ambulation (from bed to walk/back to bed) 5. Use of ambulatory aids	Wed	4 hours	Cls / Tutors
14 (04-06 Aug)					Cont. ret dem (time inclusive of those with INC ret dem in other procedures)	Mon - Wed	12	Cls / Tutors
15 (11-13 Aug)								

Nurs
Scope

NURSES make a difference

MAE
1429

Scope of Nursing

is defined by the

"who", "what", "where", "when", "why",
and "how" of nursing practice

is defined by

the nursing profession itself include

All professional specialty

ICAR Definition.

Nursing encompasses Autonomous and Collaborative
Two care of individuals of all ages, families,
communities and communities, sick or well and in all
settings. Nursing includes the promotion of health,
prevention of illness, and the care of ill, disabled and dying
people,

Scherer

18-04-14

Veri/

Nurs

Nurses make a difference

make

Advocacy, promotion of a safe
environment, research, participation in
governing health policy and patient
and health system management,
and education are also key nursing roles.

Individual
+ charts
+ family
or
group
+ high
quality
+ human

In all settings - a nurse is relevant
in all settings.

We take care of the well and sick people.

The study of Wellness -

Scope of Nursing.

• Is shaped by changes in

> Demography

> Health care delivery system (new ways to provide

patient-centered care; primary vs specialty care; care in
community vs acute care settings).

7. Society's demands for safe, quality and
affordable care

Legislation

History, culture, equity and policy barriers

2014-4-18

NURS

NURSES make a difference

MAE

1507

Society's demand for SAFE, QUALITY and affordable - clients

Clear

* (Hes) require a product -

* INTERNET, Technology -

Slope of nursing is shaped by changes in
? History,

Categories of nurses now borders medical -
NURSE PRACTITIONERS #

2nd WORLD - countries #

Regulatory and policy barriers -

What shapes the Slopes of nursing?

Define basic competencies allowed by this syllabus.

SHD4

(Sinks, articles)

The less confident the learner is the more tutored.

The more confident

Examine a client - patient -

Documentation is an important part of nursing -

Student's position - compassion - How well are you

able to demonstrate that care - Learning the
patient who is not confident -

Semester 2

18-06-14

YEAR 1

1540

Spending time with pt for wellness.

1: ^{CAT.} Adult nursing

2: Mental Nursing

3: Learning & disability Nursing

4: Paediatric nursing

Traditional

5: School health nurse

6: Prison Nurse

7: Specialist: operating theatre - OT NURSE

Bi

8: Bank staff.

Community nurse: together - pre-op - adult - home -

School nurse - 1

ICU - Intensive care nurse

Children's nurse. neonatal nurses -
work with parents & infantsMental care - by community nurse - field -
heart beat -Oncology nurse; oncology nurse; Emergencies
nurses - visiting nurse - Public Health nurse,
Nurse Educator - Research nurse.

CORE Qualities.

- Caring and compassionate and empathic
- Communication Skills (verbal/non verbal) C
- interpersonal relationship (working effectively with others) IPR'S -
- ability to use knowledge gained (competence) K
- Flexibility, adaptability, resourcefulness

IPR'S

- THE NURSE KNOWS WHY SHE DOES WHAT SHE DOES.

Flexibility, adaptability, resourcefulness, RAF
FAR

www.nhs.uk/careers. nhs.uk/exploring-careers/

nursing - Assignment Description of the role

- ① Take the "interactive personality test" to find out

which area of nursing you will be suited to Find

- ② Where do you see yourself 5-10 years from now?
Choose 3 areas of nursing to follow -

Semester 1

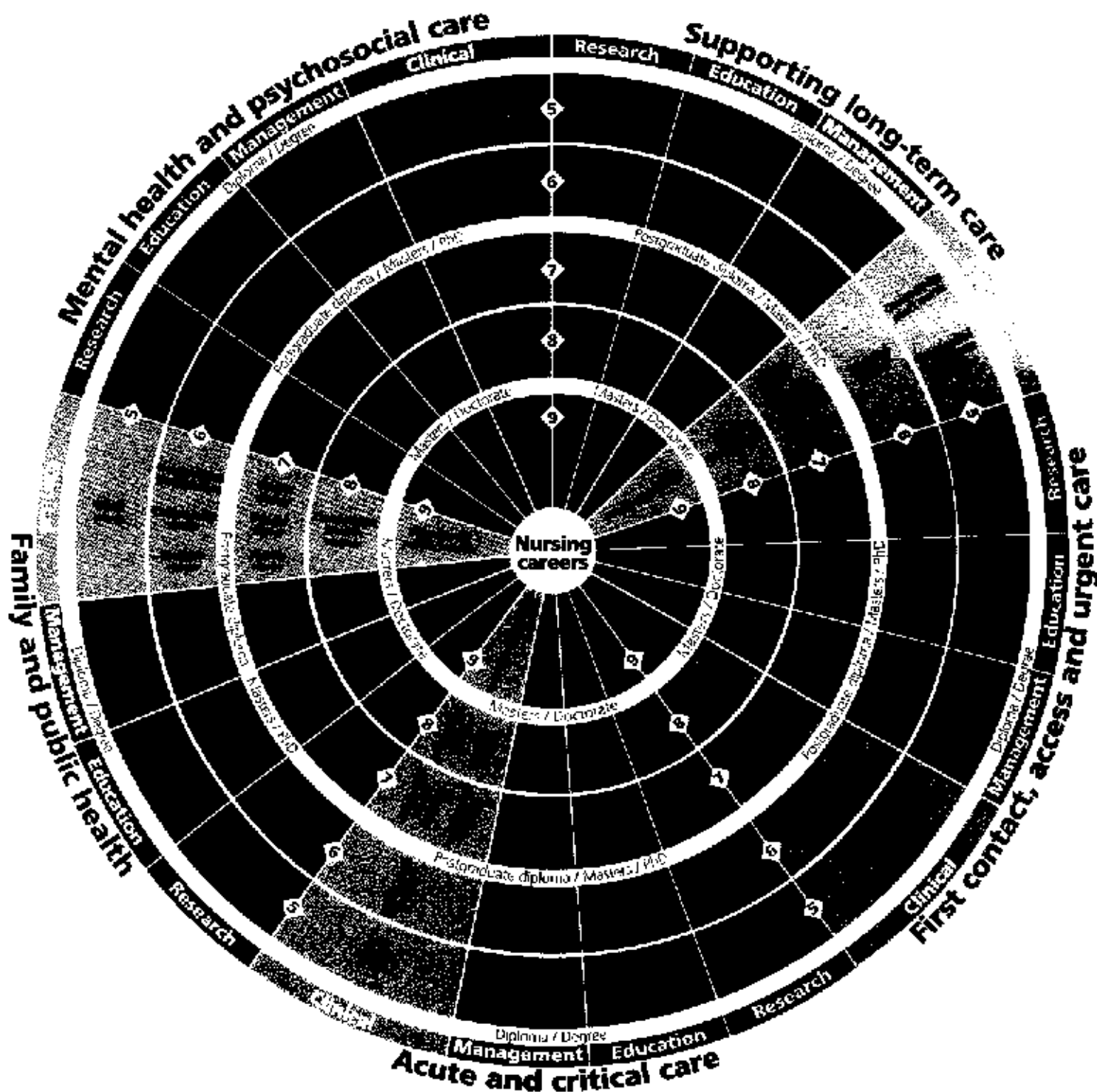
18 APRIL 2014

Version 2

Shape a quality nursing workforce

NHS

Whether you're a service manager in a primary health care team or a workforce planner for a region, you need to get the most out of your nurses. The best way to do that is to understand the profession's wide-ranging potential. For more information, visit www.nhsemployers.org



Target resources more effectively

You may have to manage your nurses across settings, from hospitals to the wider community. Or you may have to think more about how nurses provide care in pathways, from public health to acute and critical care. Whatever your exact responsibility, you will have to take an increasingly innovative approach to service design in order to deliver quality. Put the emphasis on prevention and help nurses to help children, young people, adults and older people to manage their health.

Get the best from each nurse

To design an effective nursing team, you need to consider more than just numbers of bodies. You also need to think about how much more value can be leveraged from nurses working at higher levels on the NHS Career Framework. It's crucial to get a good mix of roles at the right levels:

- Level 5 – Practitioner
- Level 6 – Senior practitioner
- Level 7 – Advanced practitioner
- Level 8 – Consultant practitioner
- Level 9 – Senior leader

Educate and develop

To deliver successful outcomes for your clients, you need to support your nurses in their professional development. Nurses given the right education and training (with early opportunities for postgraduate achievement) are better equipped to work with doctors, physiotherapists, pharmacists, radiographers and others – including healthcare support workers. They are also better able to support service users' smooth movement across the healthcare system, to ensure that they experience high-quality, safe and effective care at all times.

Balance the nursing skills mix

As nurses progress from their first job up to the executive board, they build on their skills as practitioners, partners and leaders. Each nurse can offer you these core competencies:

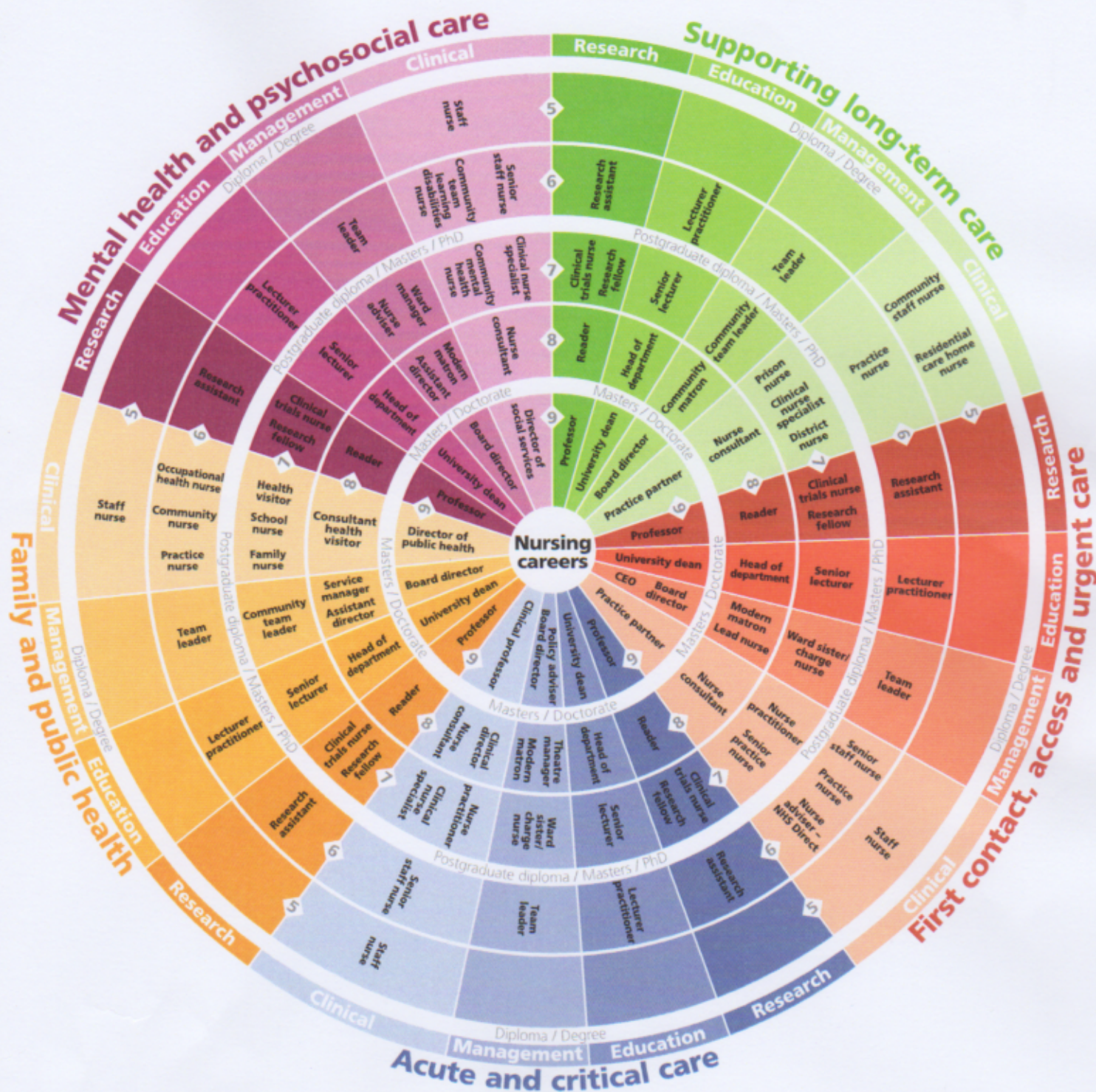
- Autonomy and accountability
- Advocacy and negotiation
- Assessment and referral
- Decision-making and clinical skills
- Managing complexity
- Caseload management
- Care pathway co-ordination

For more details, visit www.skillsforhealth.org.uk

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- Assessment and referral
- Decision-making and clinical skills
- Managing complexity
- Caseload management
- Care pathway co-ordination.

For more details, visit www.skillsforhealth.org.uk

Key Elements of the Career Framework

9

Career Framework Level 9

People working at level 9 require knowledge at the most advanced frontier of the field of work and at the interface between fields. They will have responsibility for the development and delivery of a service to a population, at the highest level of the organisation. **Indicative or Reference title: Director**

8

Career Framework Level 8

People at level 8 of the career framework require highly specialised knowledge, some of which is at the forefront of knowledge in a field of work, which they use as the basis for original thinking and/or research. They are leaders with considerable responsibility, and the ability to research and analyse complex processes. They have responsibility for service improvement or development. They may have considerable clinical and/or management responsibilities, be accountable for service delivery or have a leading education or commissioning role.

Indicative or Reference title: Consultant

7

Career Framework Level 7

People at level 7 of the career framework have a critical awareness of knowledge issues in the field and at the interface between different fields. They are innovative, and have a responsibility for developing and changing practice and/or services in a complex and unpredictable environment. **Indicative or Reference title: Advanced Practitioner**

6

Career Framework Level 6

People at level 6 require a critical understanding of detailed theoretical and practical knowledge, are specialist and / or have management and leadership responsibilities. They demonstrate initiative and are creative in finding solutions to problems. They have some responsibility for team performance and service development and they consistently undertake self development. **Indicative or Reference title: Specialist/Senior Practitioner**

5

Career Framework Level 5

People at level 5 will have a comprehensive, specialised, factual and theoretical knowledge within a field of work and an awareness of the boundaries of that knowledge. They are able to use knowledge to solve problems creatively, make judgements which require analysis and interpretation, and actively contribute to service and self development. They may have responsibility for supervision of staff or training. **Indicative or Reference title: Practitioner**

4

Career Framework Level 4

People at level 4 require factual and theoretical knowledge in broad contexts within a field of work. Work is guided by standard operating procedures, protocols or systems of work, but the worker makes judgements, plans activities, contributes to service development and demonstrates self development. They may have responsibility for supervision of some staff. **Indicative or Reference title: Assistant/Associate Practitioner**

3

Career Framework Level 3

People at level 3 require knowledge of facts, principles, processes and general concepts in a field of work. They may carry out a wider range of duties than the person working at level 2, and will have more responsibility, with guidance and supervision available when needed. They will contribute to service development, and are responsible for self development. **Indicative or Reference title: Senior Healthcare Assistants/Technicians**

2

Career Framework Level 2

People at level 2 require basic factual knowledge of a field of work. They may carry out clinical, technical, scientific or administrative duties according to established protocols or procedures, or systems of work.

Indicative or Reference title: Support Worker

1

Career Framework Level 1

People at level 1 are at entry level, and require basic general knowledge. They undertake a limited number of straightforward tasks under direct supervision. They could be any new starter to work in the Health sector, and progress rapidly to Level 2. **Indicative or Reference title: Cadet**

From: ephost@epnet.com
Subject: Spleen Filter functions
Date: April 21, 2014 at 8:12 PM
To: aboo.b.s.fatally@live.com

Record: 1

Title: The Spleen
Authors: Petroianu, Andy
Publication Information: Hilversum, the Netherlands : Bentham Science Publishers. 2011
Description: eBook.
Subjects: Spleen
Glands
Categories: SCIENCE / Applied Sciences
TECHNOLOGY & ENGINEERING / Reference
TECHNOLOGY & ENGINEERING / Inventions
Related ISBNs: 9781608050826. 9781608052738.
Accession Number: 500714

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CHAPTER 2

Functions of the Spleen and their Evaluation

Catalin Vasilescu*

Fundeni Institute of Digestive Disease and Liver Transplantation, 258 Fundeni Street, Bucharest, Romania

Abstract: The spleen receives 5% of the total cardiac output every minute and less than 10% of the blood in the arterial capillaries is emptied directly in the venous sinuses. It is also a major site for the synthesis of tuftsin and properdin, two proteins which serve as opsonins. This organ is the largest lymphoid tissue of the body. Most of the splenic functions of fight against pathogens may be taken over by other organs. The major known functions of spleen are removal of aging erythrocytes and recycling of iron, elicitation of immunity, and supply of erythrocytes after hemorrhagic shock and removes intraerythrocyte inclusions. Up to 30% of platelets are stored within the average spleen and can be released in response to specific stimuli such as epinephrine. Splenic function can be assessed most simply by searching for Howell-Jolly bodies. The spleen can be visualized and its size estimated by scintillation scanning following injection of isotope-labelled, autologous, heat-damaged red cells, which are selectively removed by functional splenic tissue.

Key Words: Spleen, Functions, Phagocytosis, Hematopoiesis, Metabolism, Immunology, Filtering.

SPLENIC FUNCTIONS: AN OVERVIEW

The spleen receives 5% of the total cardiac output every minute and less than 10% of the blood in the arterial capillaries is emptied directly in the venous sinuses. Blood reaches in large amount the splenic red pulp, a filter

engaged in the removal of particulate matter and aged and/or damaged red blood cells [1].

Ninety per cent of the blood entering the spleen empties into the "open circulation" of the red pulp, and the blood is then forced into the sinuses. This means that the blood cells and other particles contained in the blood are required to circulate along the fine meshwork of the splenic cords until they can squeeze through tiny 0.5 to 2.5 μm pores between endothelial cells lining the walls of the venous sinuses to enter the venous circulation. This delayed microcirculation allows time for splenic phagocytes to remove even poorly opsonized bacteria [2,3].

Animal studies with intravenous radiolabelled bacteria showed that the liver can effectively clear the bulk of well opsonized bacteria but the spleen is a more efficient filter in removing poorly opsonized bacteria, which are predominantly encapsulated organisms. The spleen is also the main site of synthesis of immunoglobulin M (IgM) antibody and serum IgM levels fall after splenectomy [2].

The spleen is also a major site for synthesis of tuftsin and properdin, two proteins which serve as opsonins. The serum levels of tuftsin, a basic tetrapeptide that coats the surface of neutrophils to promote phagocytosis, is subnormal after splenectomy [2,3].

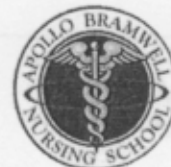
Removal of the spleen results in decreased serum levels of these factors. Properdin can initiate the alternative pathway of complement activation to produce destruction of bacteria as well as foreign and abnormal cells. Tuftsin is a tetrapeptide that enhances the phagocytic activity of both polymorphonuclear leukocytes and mononuclear phagocytes. The spleen is the major site of cleavage of tuftsin from the heavy chain of IgG, and circulating levels of tuftsin are suppressed in asplenic subjects.

The spleen is the largest lymphoid tissue of the body. The white pulp represents the immunological compartment of the organ with both antigens and lymphocytes and is divided into B and T lymphocyte zones [1].

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Andy Petroianu (Ed)

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Life Sciences for Nursing: NURS 1002 (A)
Course Plan

Batch 5

Time: 8:00-12:00

Week	Concepts	Days	# of Hours	Lecturer
1 17-18 / 04	I. Systems approach as applied to the Human Body	Thursday Friday	7 hours	BM Degorio
2 24-25 / 04	II. Cells, Tissues and Membranes	Thursday Friday	7 hours	BM Degorio
3 02 / 05	Laboratory	Friday	3.5 hours	BM Degorio
May 2, 2014	Summative test in Intro, Cells, Tissue and Membranes			
May 2, 2014	Lab Worksheet in Intro, Cells, Tissue and Membranes			
4 08-09/05	III. Microbiology ➤ A- B (History to Scope) ➤ C Microorganism	Thursday Friday	7 hours	BM Degorio
May 15, 2014	Assignment/Group Work Microbiology			
5 15-16 / 05	Laboratory IV. The Integumentary system	Thursday Friday	3.5 Hours 3.5 hours	BM Degorio F. Chadee
6 22-23 / 05	Laboratory V. Skeletal System ➤ A- B Function to Axial and Appendicular skeleton	Thursday Friday	3.5 hours 3.5 hours	F. Chadee BM Degorio
May 22, 2014	Summative Test In Integumentary System			
7 29-30 / 05	➤ C-D Bone structure to Bone formation/development ➤ E- H Articulation to Age related changes	Thursday Friday	3.5 hours 3.5 hours	BM Degorio
8 05-06 / 06	Laboratory VI. The Muscular System ➤ A- C Major functions to Muscle contraction	Thursday Friday	3.5 hours 3.5 hours	BM Degorio
June 5, 2015	Summative Test in Skeletal System			
June 5, 2014	Moving Exam in Skeletal System			
09 -27 /06	CLINICAL PLACEMENT			
9 03-04 / 07	➤ D- E Major muscles and changes across lifespan Laboratory	Thursday Friday	3.5 hours 3.5 hour	
July 4 2014	Lab Worksheet in Musculoskeletal System			
10 10-11 / 07	VII. The Nervous system ➤ A- B Central and Peripheral to Specific functions	Thursday Friday	7 hours	MF Taher
July 11 2014	Poster Making (group Work)			
11 17-18 / 07	➤ Cranial and spinal nerves ➤ E- H Composition of CSF to Developmental changes	Thursday Friday	3.5 hours 3.5 hours	
July 17, 2014	Midtest In Neurology			
12 24-25 / 07	Continuation of unfinished material Laboratory	Thursday Friday	3.5 hours 3.5 hours	
July 24, 2014	Group Presentation on Five Senses			
July 25, 2014	Summative Test In Neurology			
July 25, 2014	Lab Worksheet in Neurology			

Apollo Bramwell Nursing School
Apollo Bramwell Hospital, Moka

Nursing Theory and Practice I (NURS1001)

Course Plan

6 units lecture; 2 units' skills lab [90 hours lecture and 90 hours skills lab]

Batch 5

Week	Topics (Lecture/Demo)	Days 8 – 12am	# of Hours	Teacher	Skills Lab (Return Demo)	Days 8 – 12 am	# of Hours	Teacher
1 (14-16 April)	I. Overview of Nursing A: Nursing as an Art B: History of Nursing C. Scope of Nursing Practice D. Evolving Roles & Specialties	Monday Tuesday Wednesday	4 hours 4 hours 4 hours	Doy Doy Mae				
2 (21-23 April)	E. Nursing Theories	Tuesday	4 hours	Bryan	- History of Nursing Group/Role Play - Grp work: sharing of Insights - Integration/Case analysis	Mon Wed	4 2 2	Bryan Bryan/Mae
3 (28-30 April)	II. Health and Illness A: Concept of health, wellness and Illness B: Nature of Man C: Models of Health and Wellness D. Levels of Care	Monday Tuesday	4 hours 4 hours	Chottoo Alith	Unit Exam or Group Work? Presentations?	Wed	???	???
4 (05-07 May)	III: Concepts in Care of Patient /Clients A. Safety & Security B. Hygiene (with demo of Nursing procedures)	Monday Tuesday Wednesday	4 hours 8 hours	Feizal Alith				
5 (12-14 May)	Continue demo of hygiene procedures	Mon	4 hours	Alith	Bed making; giving a bed bath; shampooing; back massage; offering a urinal or bedpan Oral Hygiene, perennial, nail and foot care (practice time in lab)	Tue Wed	4 hours 4 hours	CIs / Tutors

Week	Topics (Lecture/Demo)	Days 8 – 12 am	# of Hours	Teacher	Skills Lab (Return Demo)	Days 8 – 12 am	# of Hours	Teacher
6 (19-21 May)	C. Homeostasis D. Vital Signs (w/ Demo on V/S taking	Mon / Tue	8 hours	Bryan	Vital signs taking	Wed	4 hours	Cls/Tutors
7 (26-28 May)	E. Rest & Sleep F. Infection Control	Monday Tues /Wed	4 hours 8 Hours	Feizal Feizal/Mo Babita				
8 (02-04 June)					Handwashing, PPE, (Practice) Return Demo (Assessed)	Mon Tue/Wed	4 hours 8 hours	
	CLINICAL PLACEMENT I (09 – 27 June 2014)							
9 30 Jun 01-02 July)	G. Nutrition	Mon - Tue	8 hours	Ilayavalli	Nutrition Screening: 24 hr /3 day recall; biceps mmt. (workshop) Nutritional Campaign - grpwork (poster/slide presentation) Height and weight-taking Feeding an adult	Wed	4 hours	Cls / Tutors
10 (07-09 July)	H. Urinary Elimination I. Bowel Elimination	Monday Tuesday	4 hours 4 hours	Alith Alith	Specimen Collection (urine/stools) Digital removal of Stools	Wed	4 hours	Cls / Tutors
11 (14-16 July)	J. Exercise & Mobility ➤ Maintaining good posture [standing,sitting,lying] ➤ Guidelines on Good Body Mechanics ➤ Ergonomic Hazards in the Workplace ➤ Positioning Clients ○ General Principles ○ Common positions ○ Use of positioning devices	Mon -Wed	12 hrs	Feizal/Mo Alith				

Week	Topics (Lecture/Demo)	Days 8 - 12 pm	# of Hours	Teacher	Skills Lab (Return Demo)	Days 8 - 12 am	# of Hours	Teacher
12 (21-23 Jul)	➤ Dangers of Inactivity/Benefits of Regular Exercise ➤ Turning, Moving & Transferring Clients ○ Use of Assistive Devices	Monday	4 hours	Feizal & Mo	Procedures: 1. Turning & Positioning a Client in Bed 2. Moving – up a Client in Bed 3. Transferring a Client from Bed to Wheelchair 4. Transferring a Client from Bed to Stretcher 5. Shifting and Lifting Clients	Tuesday Wed	8 hours	
13 (28-30 Jul)	Relevant Procedures for Meeting Clients Need for Activity/Exercise i. Performing Passive Range of Motion Exercises (PROM) ii. Assisting Clients do Passive and Active Exercises iii. Assisting with Ambulation ○ Assisting Clients with Ambulatory Aids	Monday Tuesday	8 hours	Bryan	1. PROM 2. Isometric Exercises 3. Passive and active Exercises 4. Ambulation (from bed to walk/back to bed) 5. Use of ambulatory aids	Wed	4 hours	Cls / Tutors
14 (04-06 Aug)					Cont. ret dem (time inclusive of those with INC ret dem in other procedures)	Mon - Wed	12	Cls / Tutors
15 (11-13 Aug)								

13 31/07 01/08	VIII. The Endocrine System	Thursday	3.5 hours	F Chadee
	➤ A-B Role and Structure ➤ C- E Hormones Function to Feedback mechanism	Friday	3.5 hours	
August 1 2014 Assignment on Endocrine System				
14 14-15 / 08	Laboratory	Thursday	3.5 hours	
	Continuation of unfinished material (make-up for missed sessions)	Friday	3.5 hours	
August 14, 2014		Lab Worksheet on Endocrine		
August 14, 2014		Summative Test on Endocrine		

Apollo Bramwell Nursing School

Apollo Bramwell Hospital, Moka

Nursing Theory and Practice I (NURS1001)

Course Plan

6 units lecture; 2 units' skills lab [90 hours lecture and 90 hours skills lab]

Batch 5

Week	Topics (Lecture/Demo)	Days 8 – 12am	# of Hours	Teacher	Skills Lab (Return Demo)	Days 8 – 12 am	# of Hours	Teacher
1 (14-16 April)	I. Overview of Nursing A: Nursing as an Art B: History of Nursing C. Scope of Nursing Practice D. Evolving Roles & Specialties	Monday Tuesday Wednesday	4 hours 4 hours 4 hours	Doy Doy Mae				
2 (21-23 April)	E. Nursing Theories	Tuesday	4 hours	Bryan	- History of Nursing Group/Role Play - Grp work: sharing of Insights - Integration/Case analysis	Mon Wed	4 2 2	Bryan Bryan/Mae
3 (28-30 April)	II. Health and illness A: Concept of health, wellness and Illness B: Nature of Man C: Models of Health and Wellness D. Levels of Care	Monday Tuesday	4 hours 4 hours	Chottoo Alith	Unit Exam or Group Work? Presentations?	Wed	???	???
4 (05-07 May)	III: Concepts in Care of Patient /Clients A. Safety & Security B. Hygiene (with demo of Nursing procedures)	Monday Tuesday Wednesday	4 hours 8 hours	Feizal Alith				
5 (12-14 May)	Continue demo of hygiene procedures	Mon	4 hours	Alith	Bed making; giving a bed bath; shampooing; back massage; offering a urinal or bedpan Oral Hygiene, perennial, nail and foot care (practice time in lab)	Tue Wed	4 hours 4 hours	Cls / Tutors

Apollo Bramwell Nursing School
Apollo Bramwell Hospital, Moca

NURS1008: Nursing Management & Education 1
Course Plan

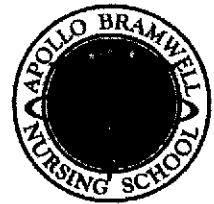
Batch 5

Week	Concepts	Days	# of Hours	Lecturer
1 st - 3 rd	I. Introduction to the module II. Nursing as a Profession	Wed	2.5 hour	Jay
16 Apr Wed	A. Exploring Concepts About Nursing	Fri	2 hours	
18 Apr Fri	B. What is a Profession?			
23 Apr Wed	C. Why is Nursing a Profession?			
25 Apr Fri	D. Competencies/Proficiency Levels			
30 Apr Wed	E. Concept of Professional Accountability			
02 May Fri	F. Elements of Professional Accountability			
	1. R/R of the Nurse			
	2. Standards of Nursing Practice			
	3. Legislative Regulation			
	3.1 Scope of Nursing Practice			
	3.2 Licensure: Its Process			
	4. Individual Accountability			
	4.1 Cont'd Competency Development			
	4.2 Professional Development			
	Unit Test			
4 th - 6 th	III. Ethico-Moral Aspects of Nursing	Wed	2.5 hours	Jay
07 May Wed	A. Concept of Ethics	Thurs	2 hours	
09 May Fri	a.1 Legal vs Ethical Concepts			
	a.2 Ethics in Health Care			
14 May Wed	B. Ethical Theories			
16 May Fri	b.1 Teology			
	b.2 Deontology			
21 May Wed	C. Ethical Principles			
23 May Fri	c.1 Autonomy			
	c.2 Non-maleficence			
	c.3 Beneficence			
	c.4 Justice			
	c.5 Veracity			
	c.6 Fidelity			
21 May Wed	D. Ethical Codes			
23 May Fri	d.1 Code of Ethics for Nurses in Mau			
	d.2 The ICN Code of Ethics for Nurses			
	d.3 The Nightingale Pledge			
	E. Ethical Decision Making			
	e.1 Framework for Ethical Decision-making			
	e.2 Application of Framework in Selected Cases			
	Unit Test			
7 th - 10 th	IV. Legal Foundations of Nursing	Wed	2.5 hours	ALITH ELITH
28 May Wed	A. Sources of the Law	Thurs	2 hours	
	a.1 Public Law			
	a.2 Civil Law			

Week	Topics (Lecture/Demo)	Days 8 – 12 am	# of Hours	Teacher	Skills Lab (Return Demo)	Days 8 – 12 am	# of Hours	Teacher
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APOLLO BRAMWELL NURSING SCHOOL
NURS 1007 – IT & COMMUNICATION SKILLS

SYLLABUS

(1.5 Credits)

MODULE CONTENT

Unit 1

Writing of report using appropriate English Language grammar/vocabulary.

Unit 11

Grammar

- The sentence
- Different parts of speech in brief

Unit 111

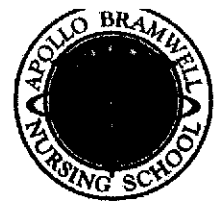
Composition

- Analysis, transformation and synthesis of sentences
- Correct usage of sentences
- Reading Comprehension – Exercise of prescribed short answers.

Unit 1V

Written Composition

- Paragraph writing
- Story writing
- Comprehension
- Precise writing
- Essay writing



Unit V

Vocabulary

- Conversation
- Speaking Skills

Unit V1

- Vocabulary in the good manner
- Words for the statement: how to ask, claim, convince, reassure...
- 1st impression: each employee is the window of the enterprise.

The positive attitude: a frame of mind which makes all the differences

- Needs of the customer
- How to deal with a customer: smile, body language, selected words
- Rules for a good communication
- The telephone reception: on the telephone the smile gets along, the importance of the 1st contact, how to make, receive, transfer and conclude a call.
- The telephone vocabulary
- Listening: how to identify a request, to know to reformulate, know to channel
- How to manage a customer.

APOLLO BRAMWELL NURSING SCHOOL

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BRC No.: C08074963

APOLLO BRAMWELL NURSING SCHOOL
C/O APOLLO BRAMWELL HOSPITAL, ROYAL ROAD, MOKA

N1007 – INFORMATION TECHNOLOGY & COMMUNICATION SKILLS
(A Resource Unit)

Module Code: NURS 1007

Module Name: Information Technology and Communication Skills

Description:

Writing of report using appropriate English Language, grammar and vocabulary; enhancing verbal communication skills. Use of the computer and managing files: Applications of basic programmes [Word, Excel, PowerPoint]

Credit: 1.5 units (30 contact hours)

Placement: First Year, First Semester

Settings: Classroom and Computer Lab

Requirements: *Continuous Assessment Assignment/Essay writing* - 50%
Tests (Vocabulary and Grammar) - 20%
Group Presentation - 30%

For IT classes: attendance at and participation in at least 90% of all scheduled teaching activities is compulsory.

Students must score at least 50% in the both continuous and end-of-term assessment

A
B
C
D

- 201 km
- 20 min 8

Learning outcomes: At the end of the module, the student will be able to:

1. Understand concepts in information technology, computer fundamentals and use of information technology in the health sector;
2. Demonstrate basic skills in computer use for a more effective contribution to their future organization;
3. Write a report using appropriate English Language, correct grammar and vocabulary;
4. Demonstrate satisfactory ability to communicate verbally and in writing the English Language.

Resources.

PILO, T. (2008) A Complete Guide to G.C.E. 'O' Level English Singapore: Fairfield Book Publishers Pte Ltd.

PILO, T. (2008) Read Up for General Paper. Singapore: Fairfield Book Publishers Pte Ltd.

HARGIE, H. (2007) THE HANDBOOK OF COMMUNICATION SKILLS. London and New York: Routledge Taylor & Francis Group.

Learning outcomes: At the end of the module, the student will be able to:

1. Understand concepts in information technology, computer fundamentals and use of information technology in the health sector;
2. Demonstrate basic skills in computer use for a more effective contribution to their future organization;
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HARGIE,H.(2007) THE HANDBOOK OF COMMUNICATION SKILLS. London and New York: Routledge Taylor & Francis Group.

1. Head length
(from hairline to back of head)

2. Head breadth
(from ear to ear)

3. Neck length
(from larynx to base of skull)

4. Neck breadth
(at the widest part)

5. Shoulder length
(from tip of shoulder to tip of shoulder)

6. Torso length
(from top of shoulder to top of hip)

7. Torso breadth
(at the widest part)

8. Hip length
(from top of hip to top of hip)

9. Head circumference
(around the head)

10. Chest length
(from top of chest to bottom of chest)

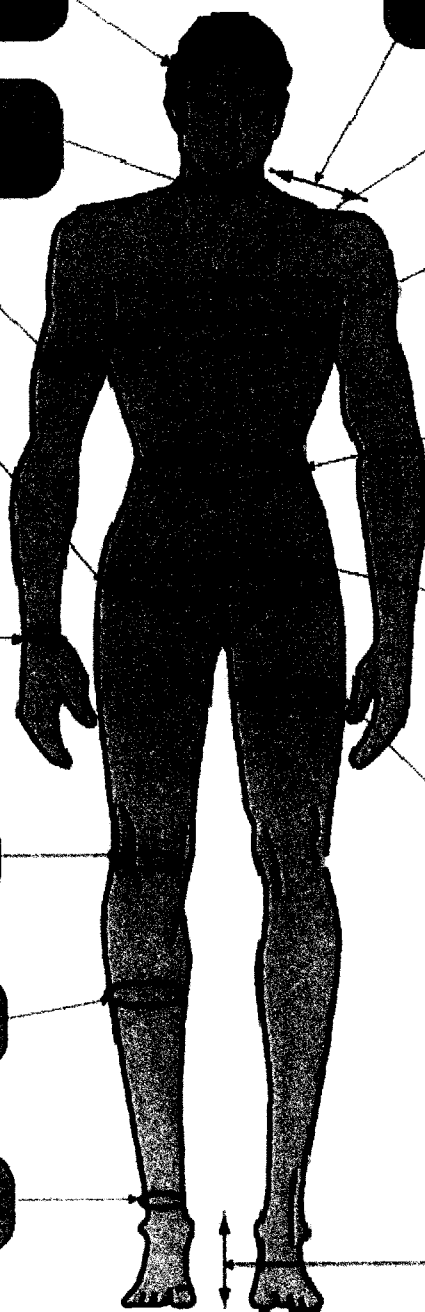
11. Chest breadth
(at the widest part)

12. Waist length
(from top of waist to bottom of waist)

13. Waist breadth
(at the widest part)

14. Hip breadth
(at the widest part)

15. Foot length
(from heel to tip of longest toe)



1. Head length
2. Head width

3. Neck length
4. Neck width

5. Shoulder length
6. Shoulder width

7. Elbow length
8. Elbow width

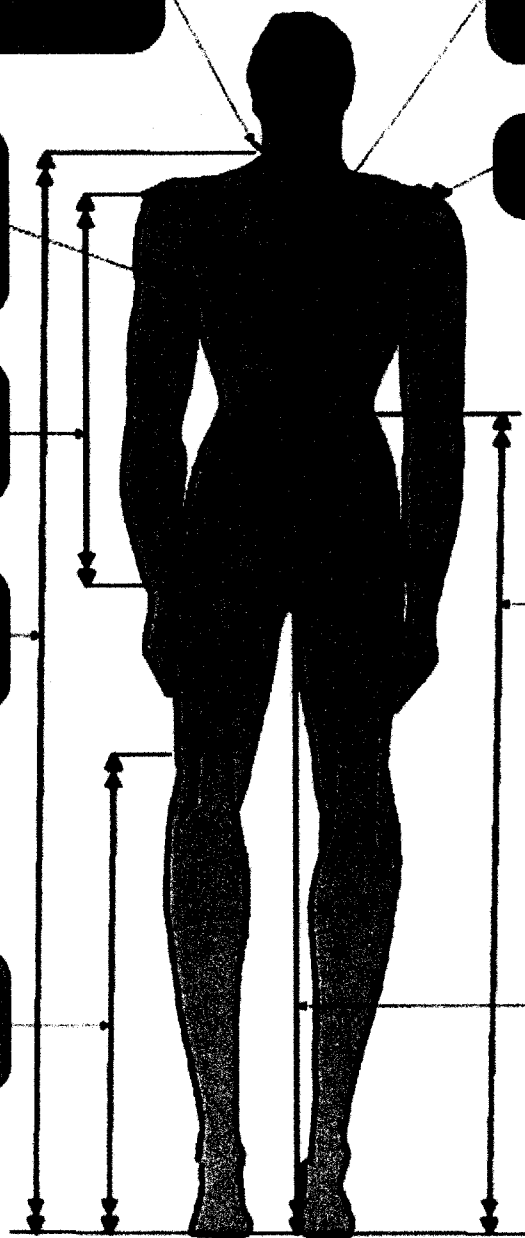
9. Wrist length
10. Wrist width

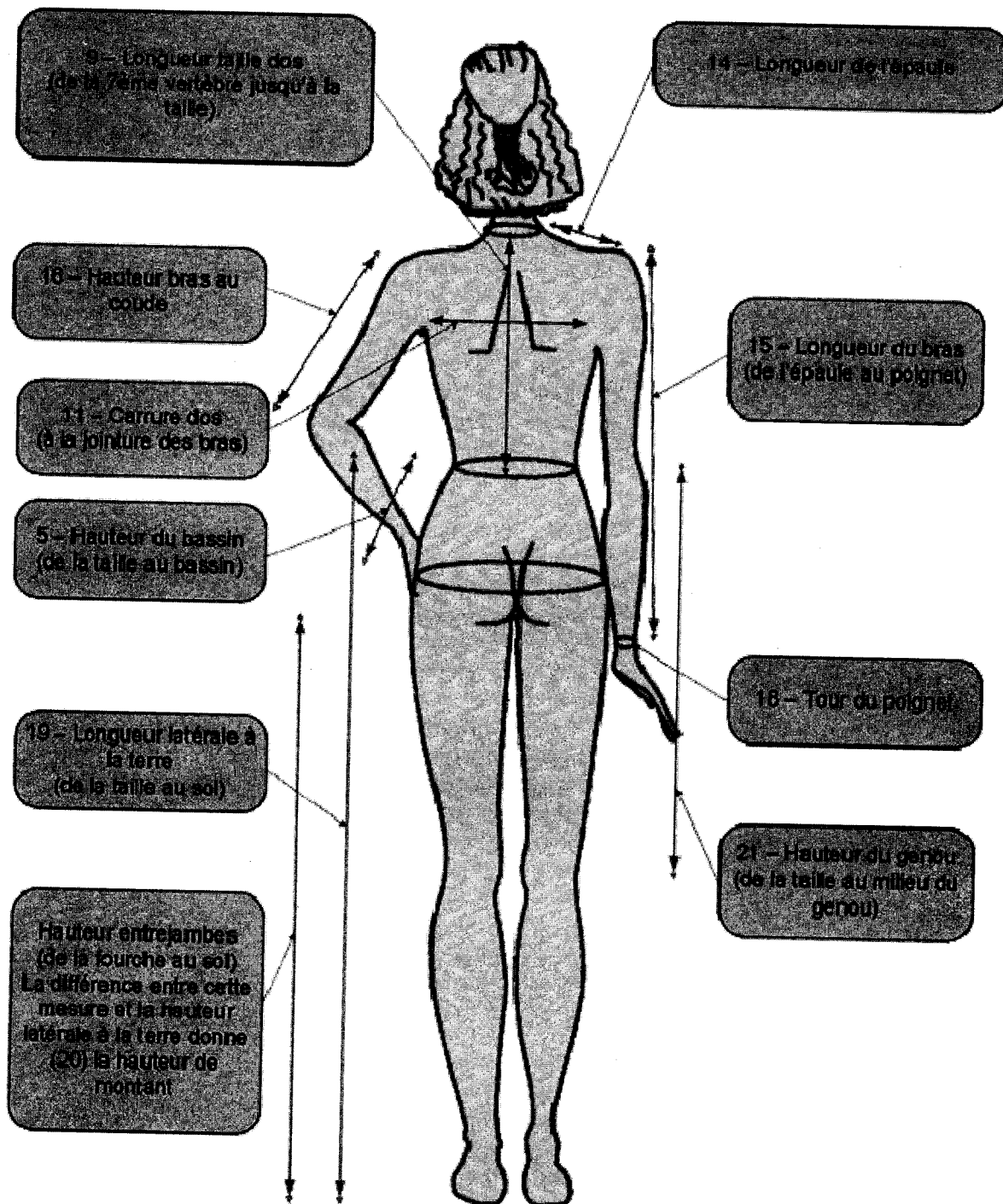
11. Hip length
12. Hip width

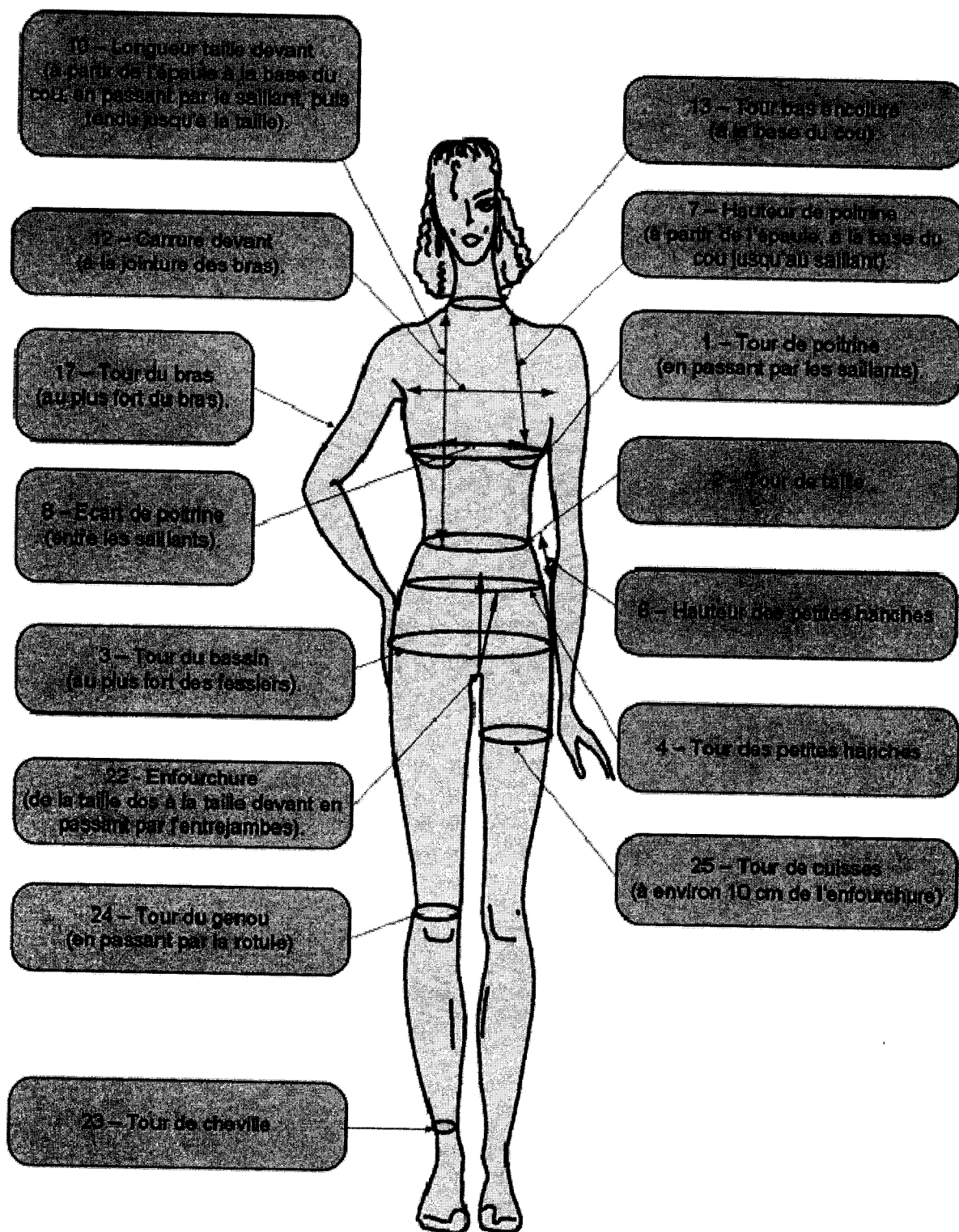
13. Knee length
14. Knee width

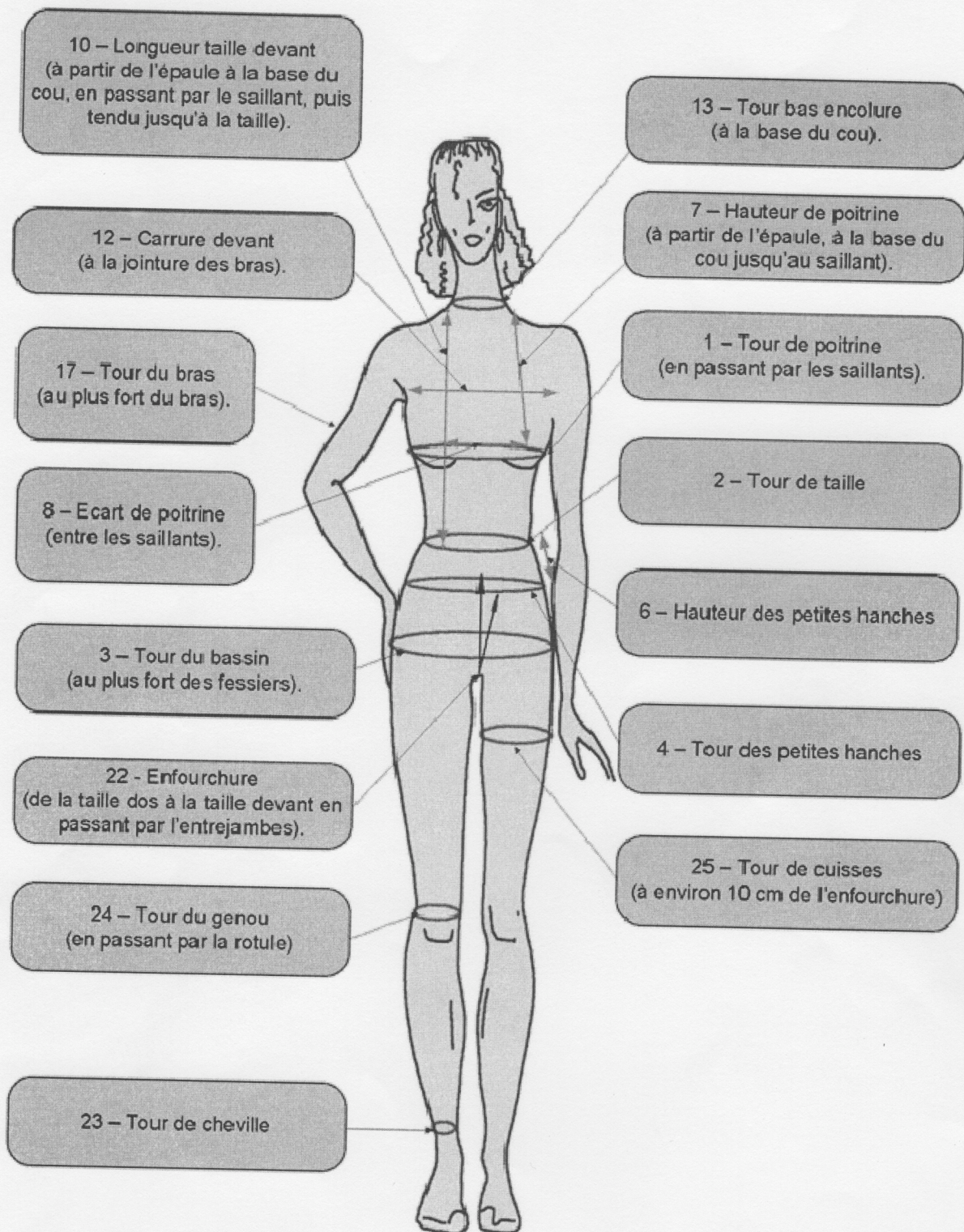
15. Ankle length
16. Ankle width

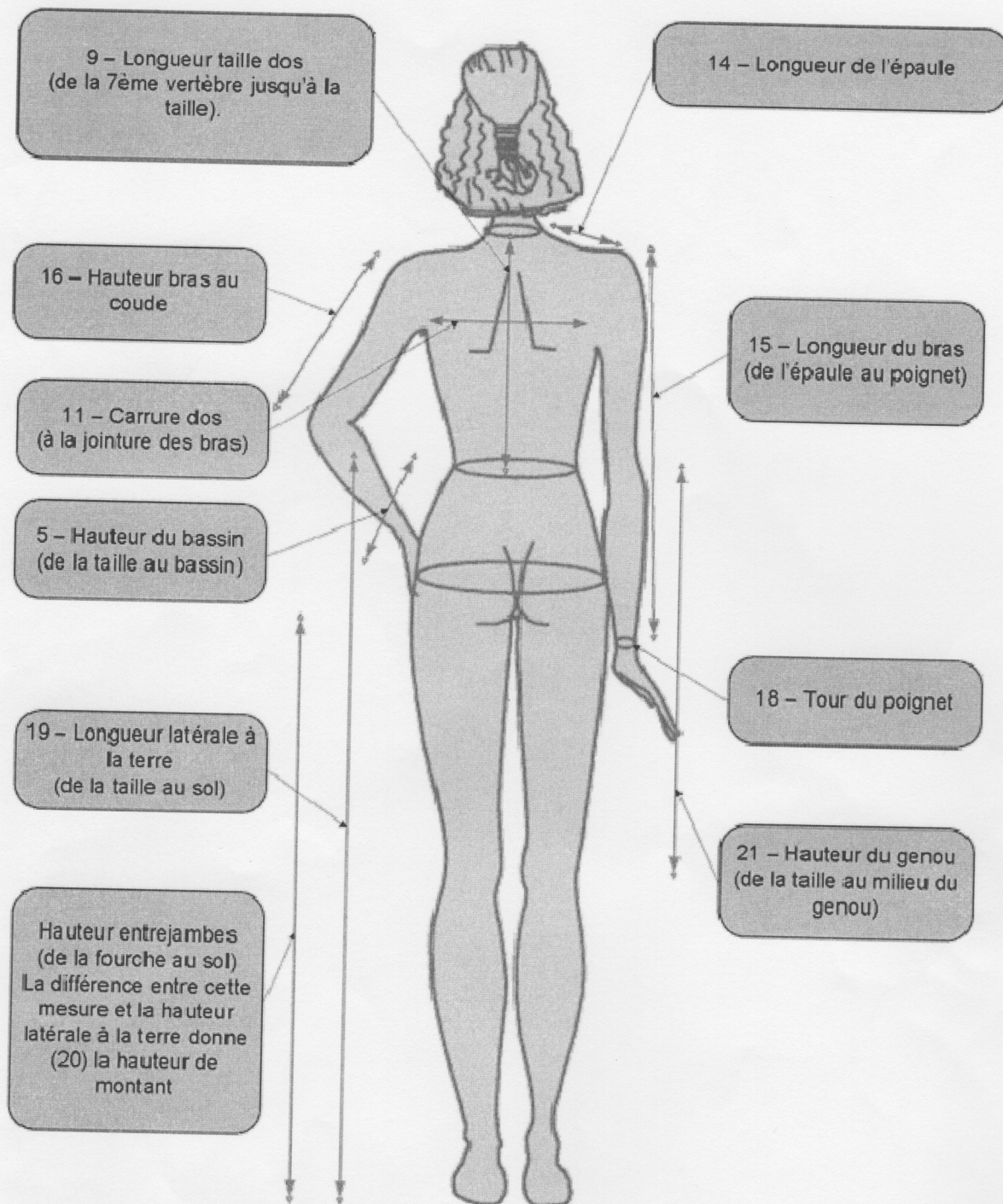
17. Foot length
18. Foot width

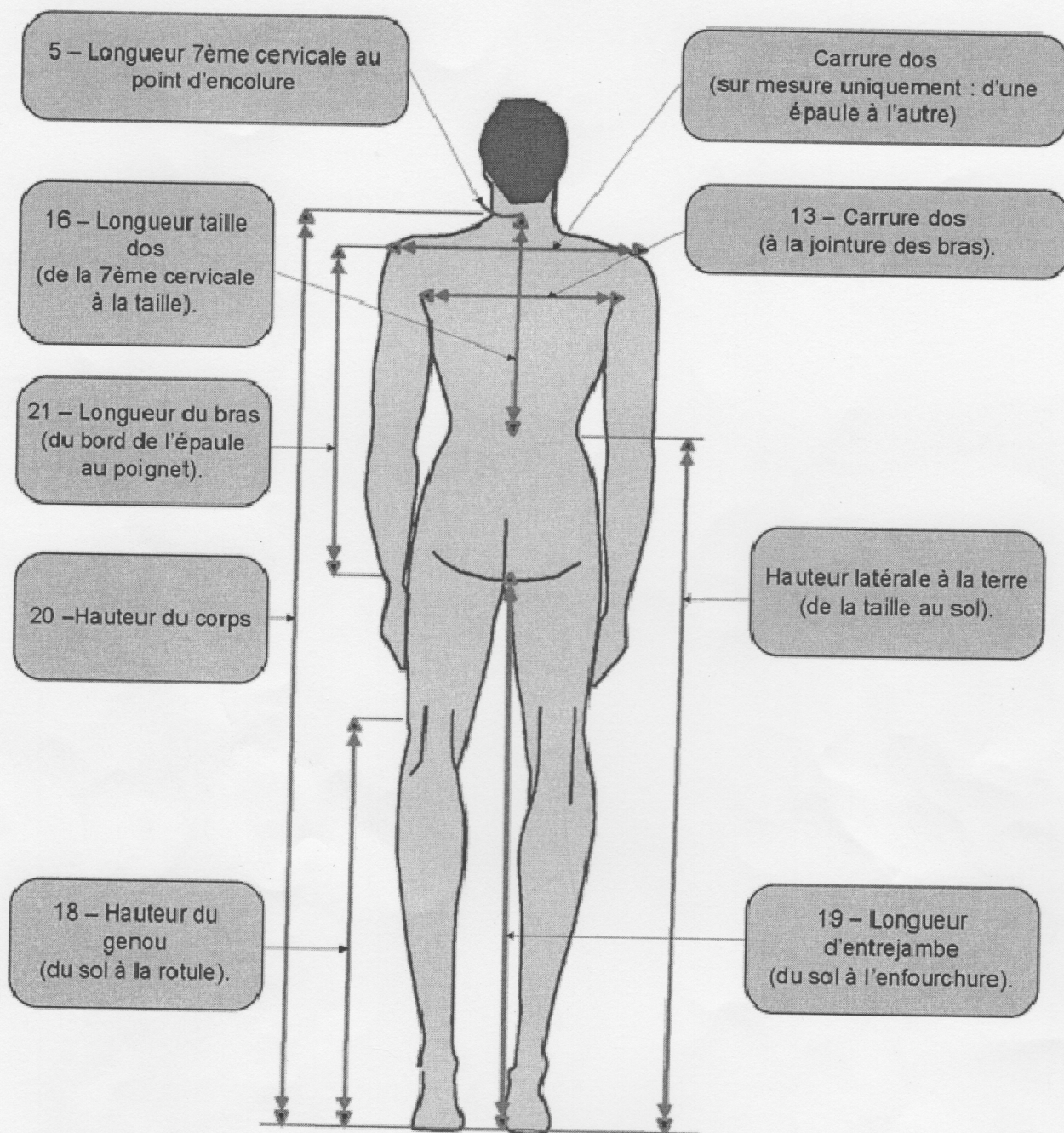


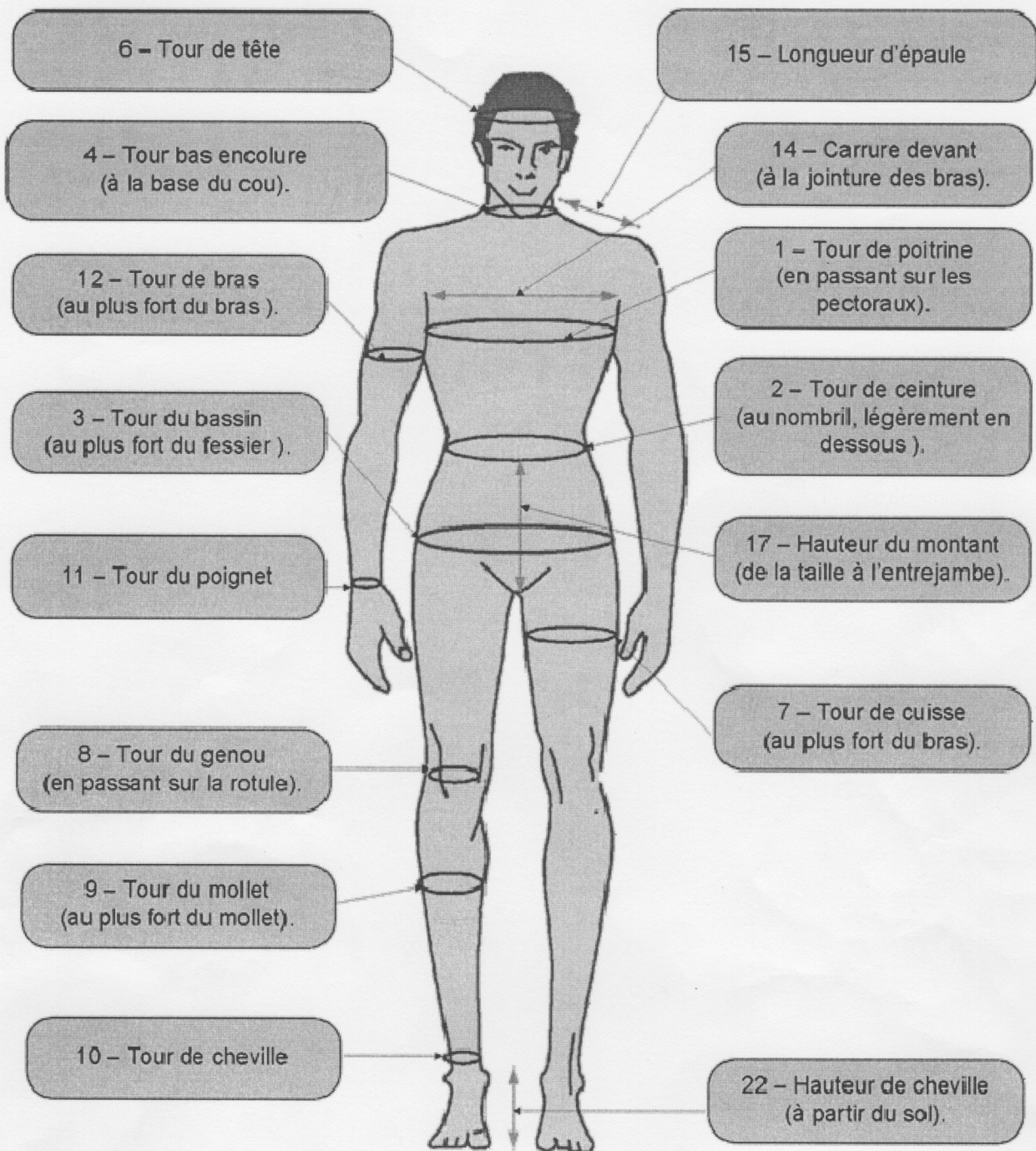


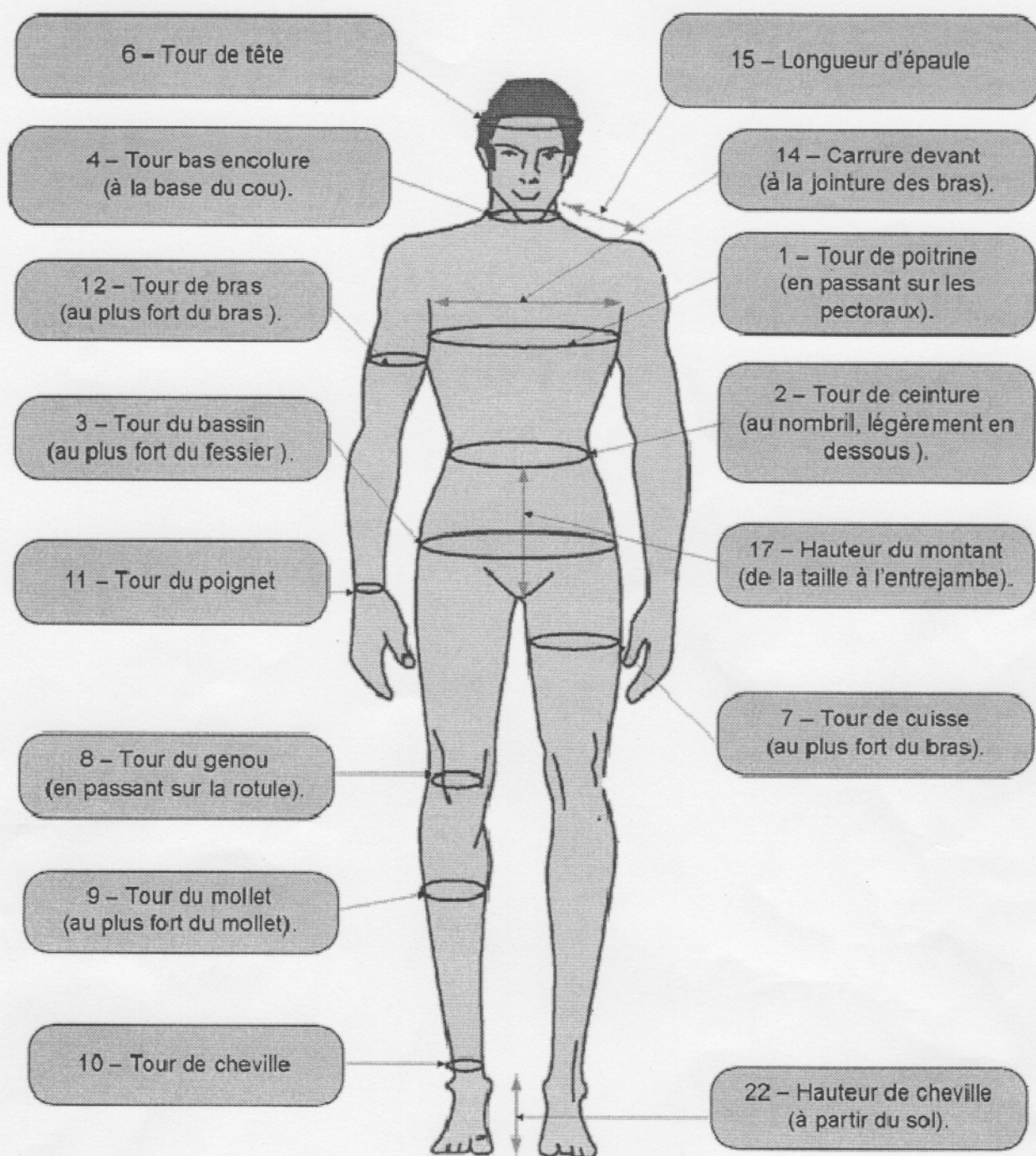


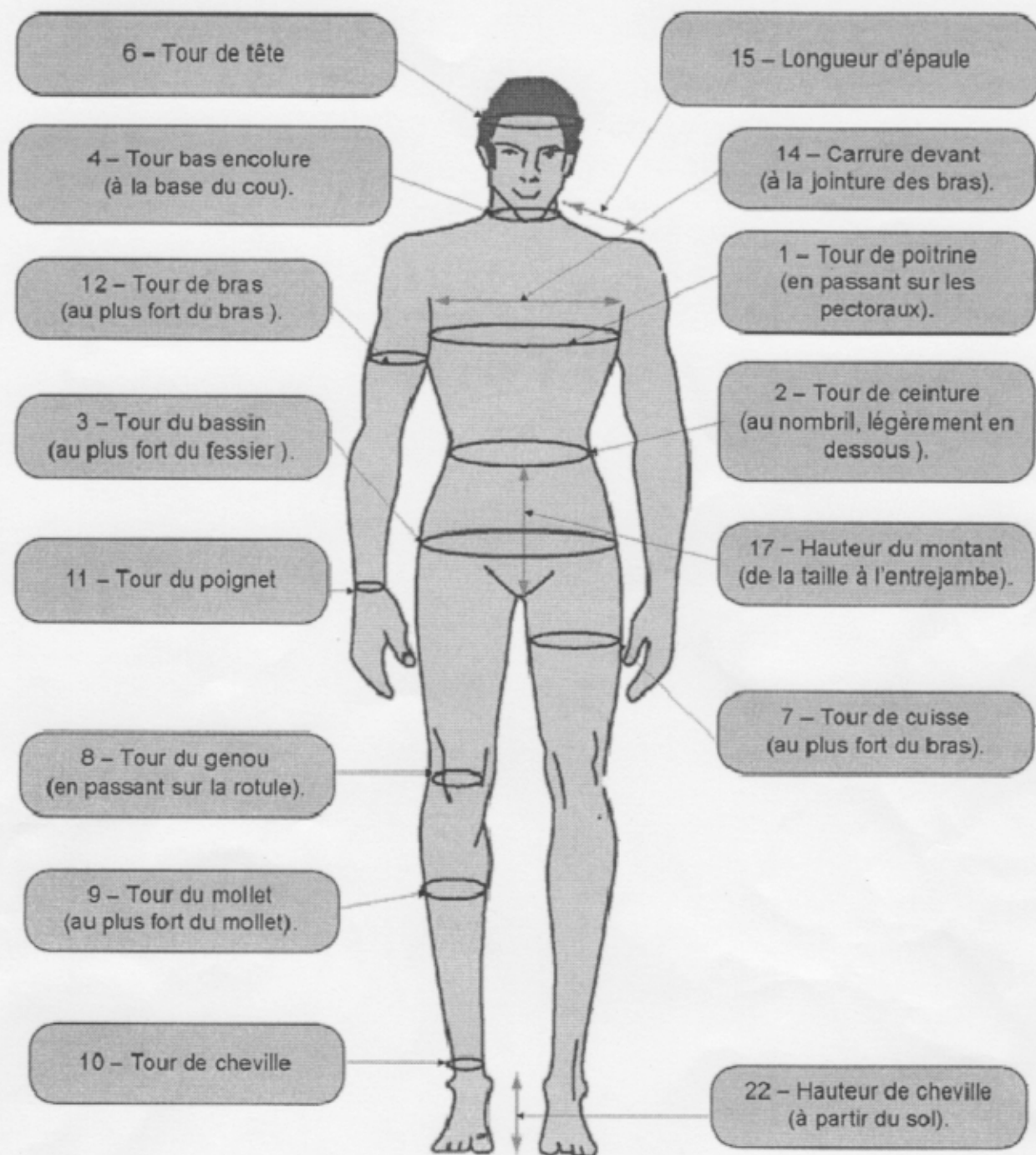


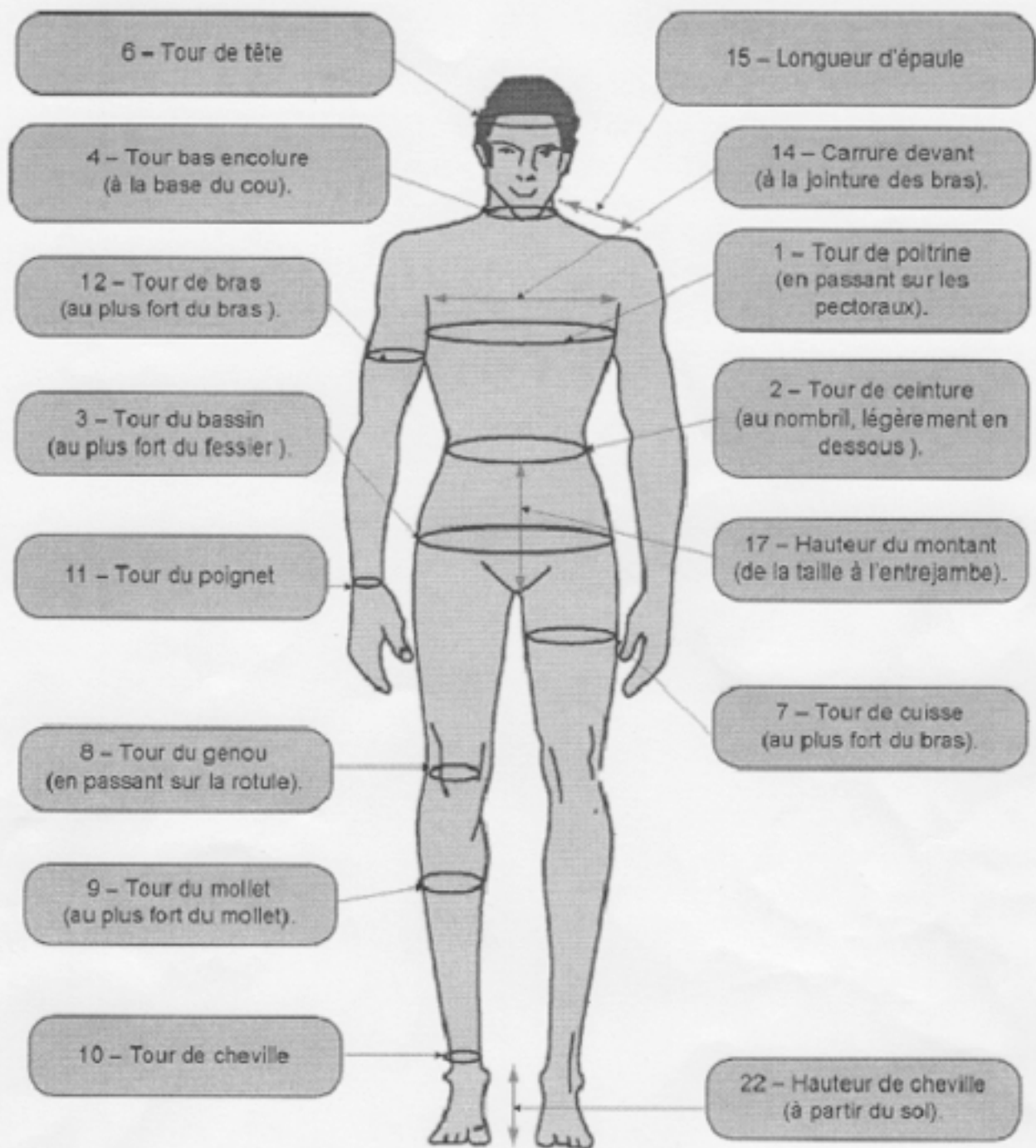


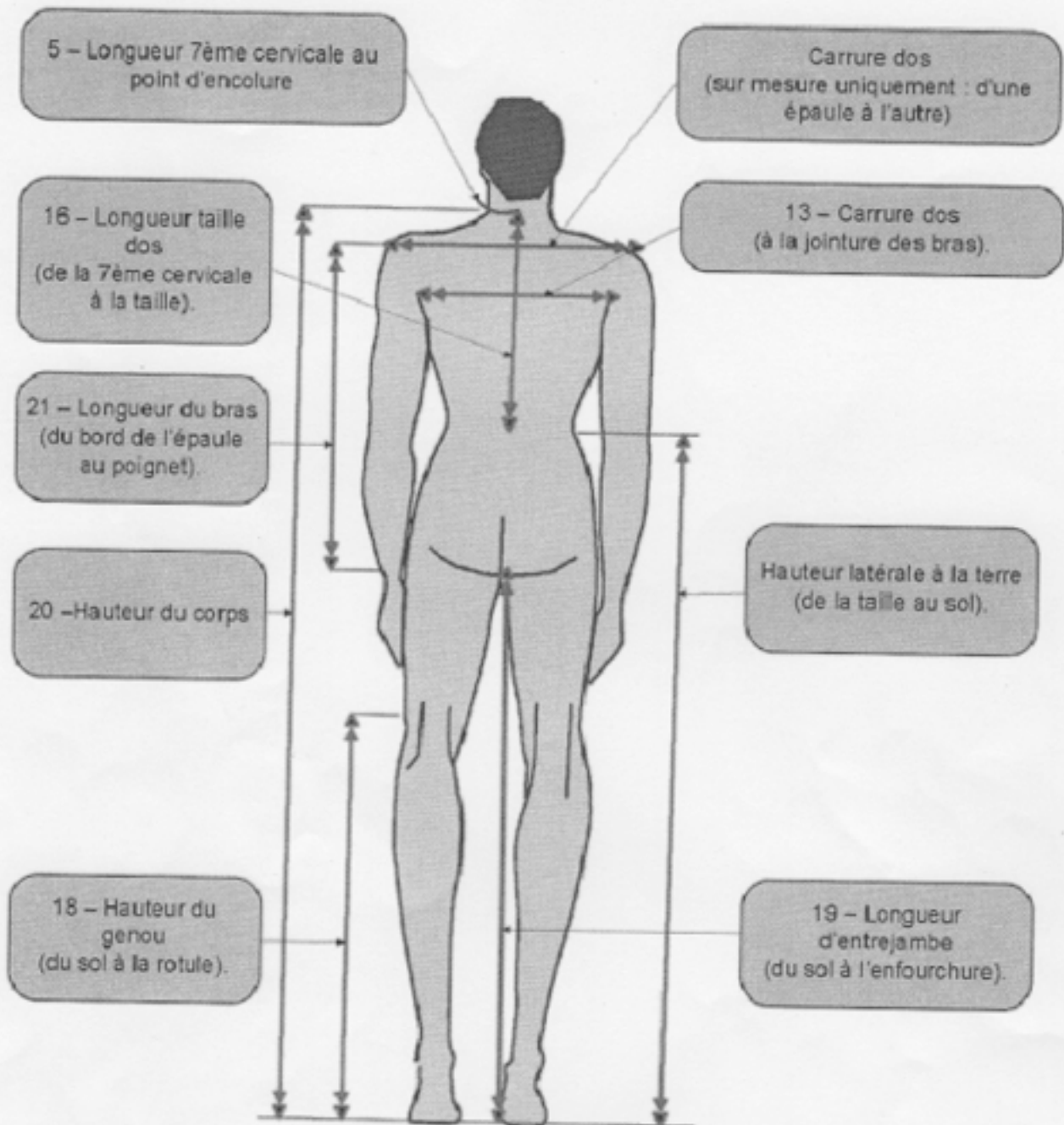


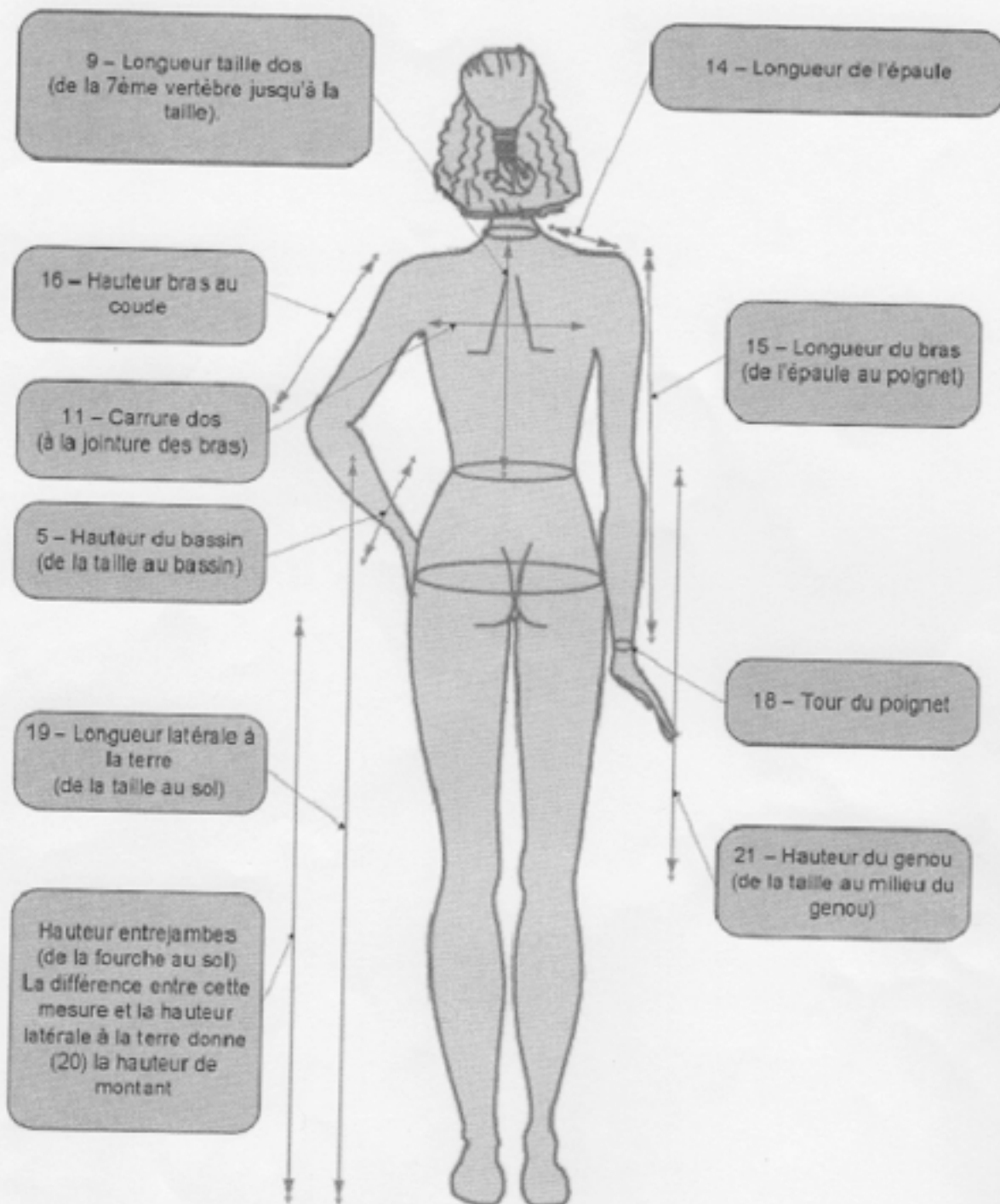


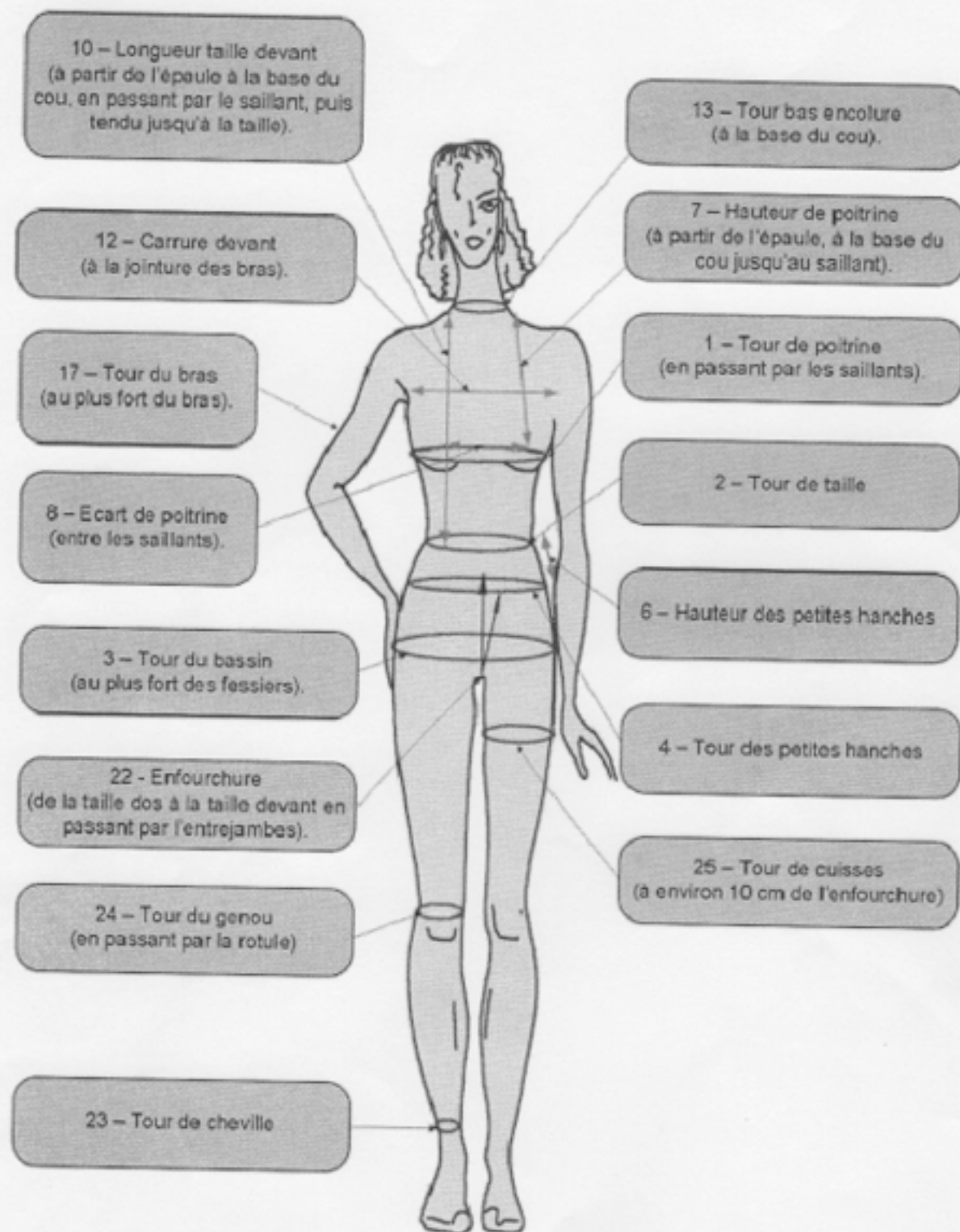












EVALUATION OF THE MEASUREMENT OF CLINICAL AND BIOCHEMICAL PARAMETERS IN THE MONITORING OF THE THERAPEUTIC EFFECT OF THE TREATMENT OF PATIENTS WITH CHRONIC HEPATITIS C

[illegible]

BATCHES - MEASUREMENT OF CLINICAL UNIFORMS

[illegible]

(in cm)

1/ 107
2/ 103
3/ 109
4/ 43
5/ 54
6/ 60
7/ 62
8/ 42
9/ 42

10/ 30
11/ 20
12/ 39
13/ 44
14/ 41
15/ 19
16/ 47
17/ 27
18/ 50
19/ 80
20/ 152
21/ 59
22/ 10

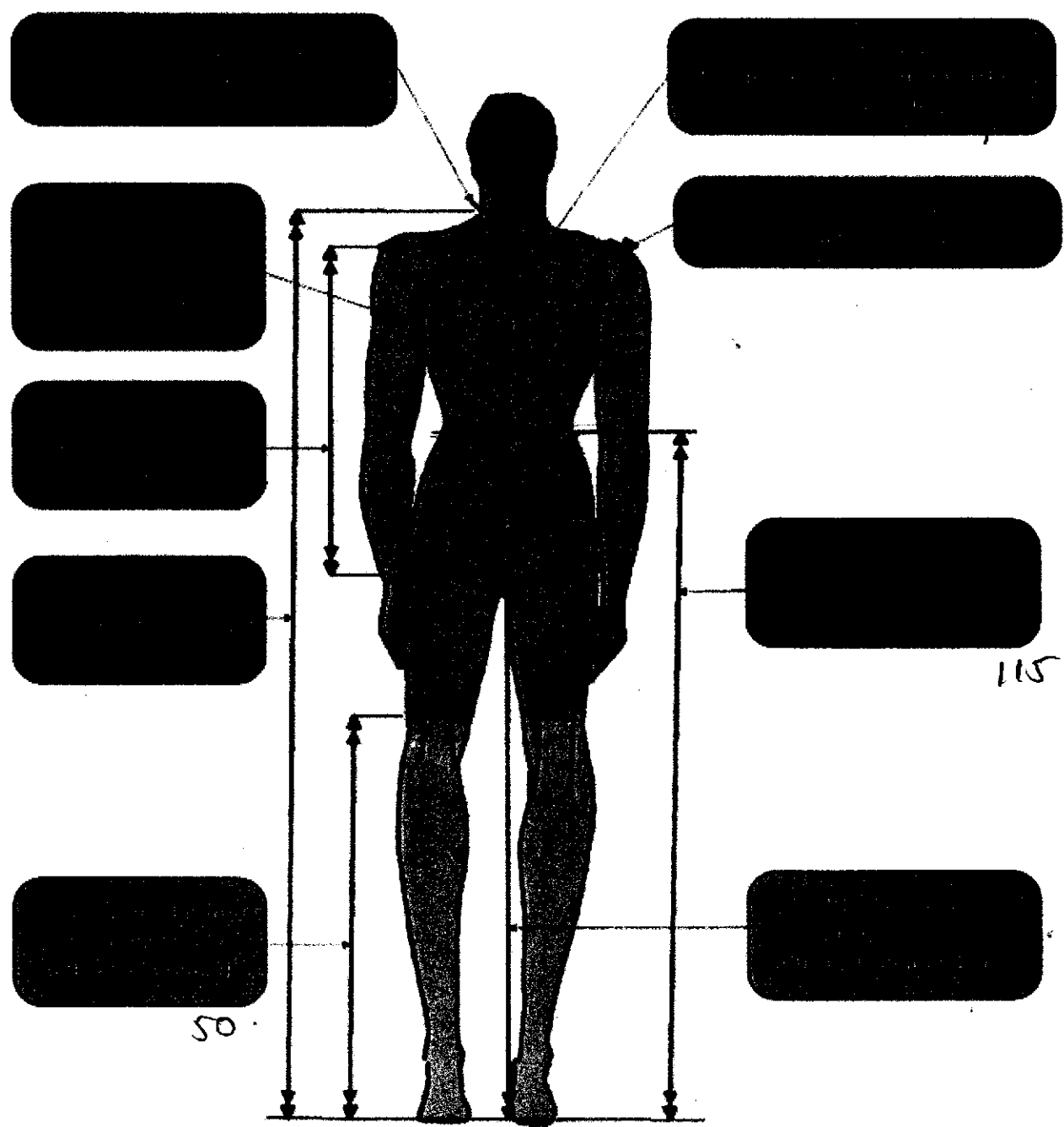
56 Carrure dos (d'être égal à l'autre)

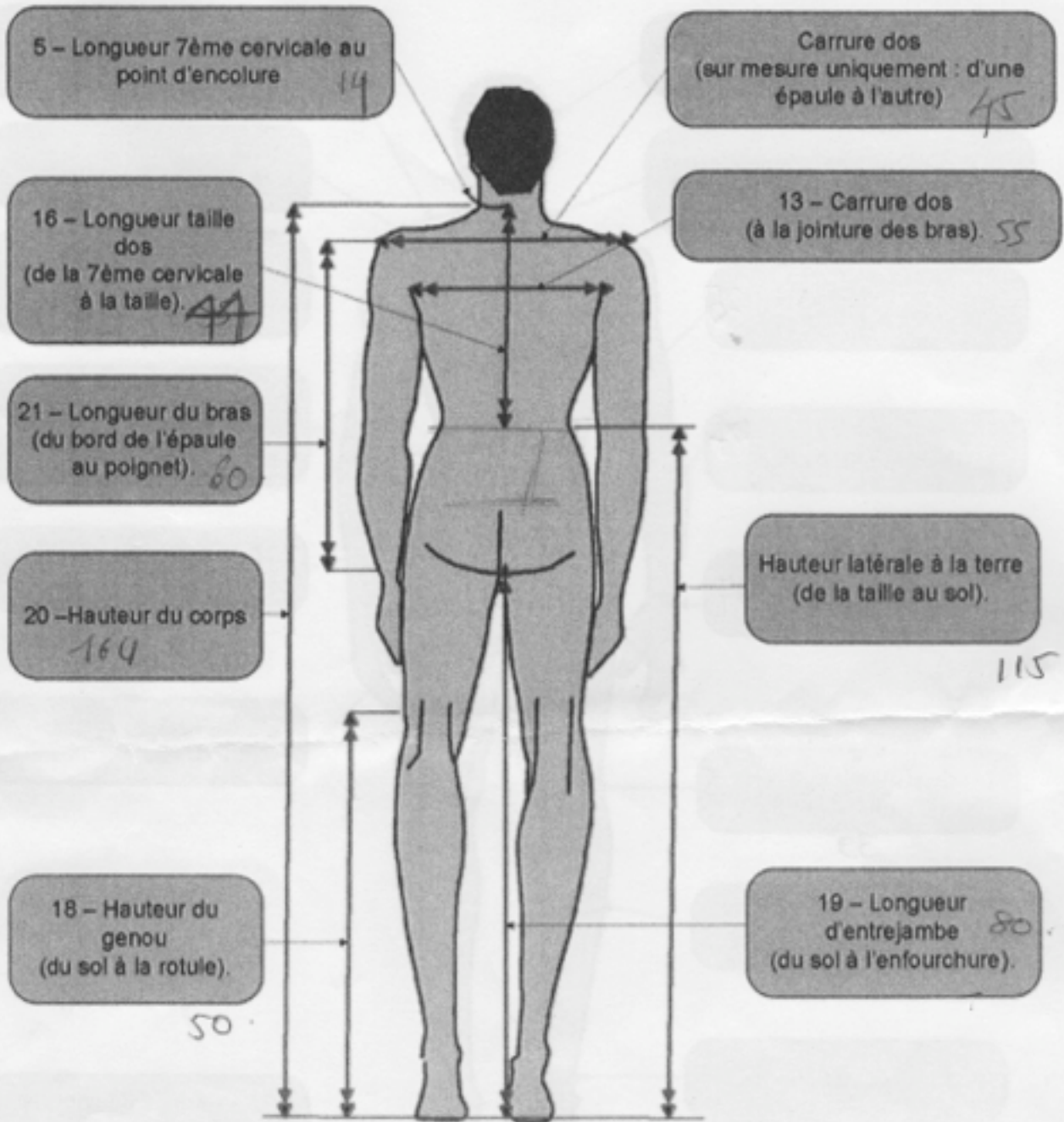
105 Hauteur (de la taille au sol.)
Laterale à la terre

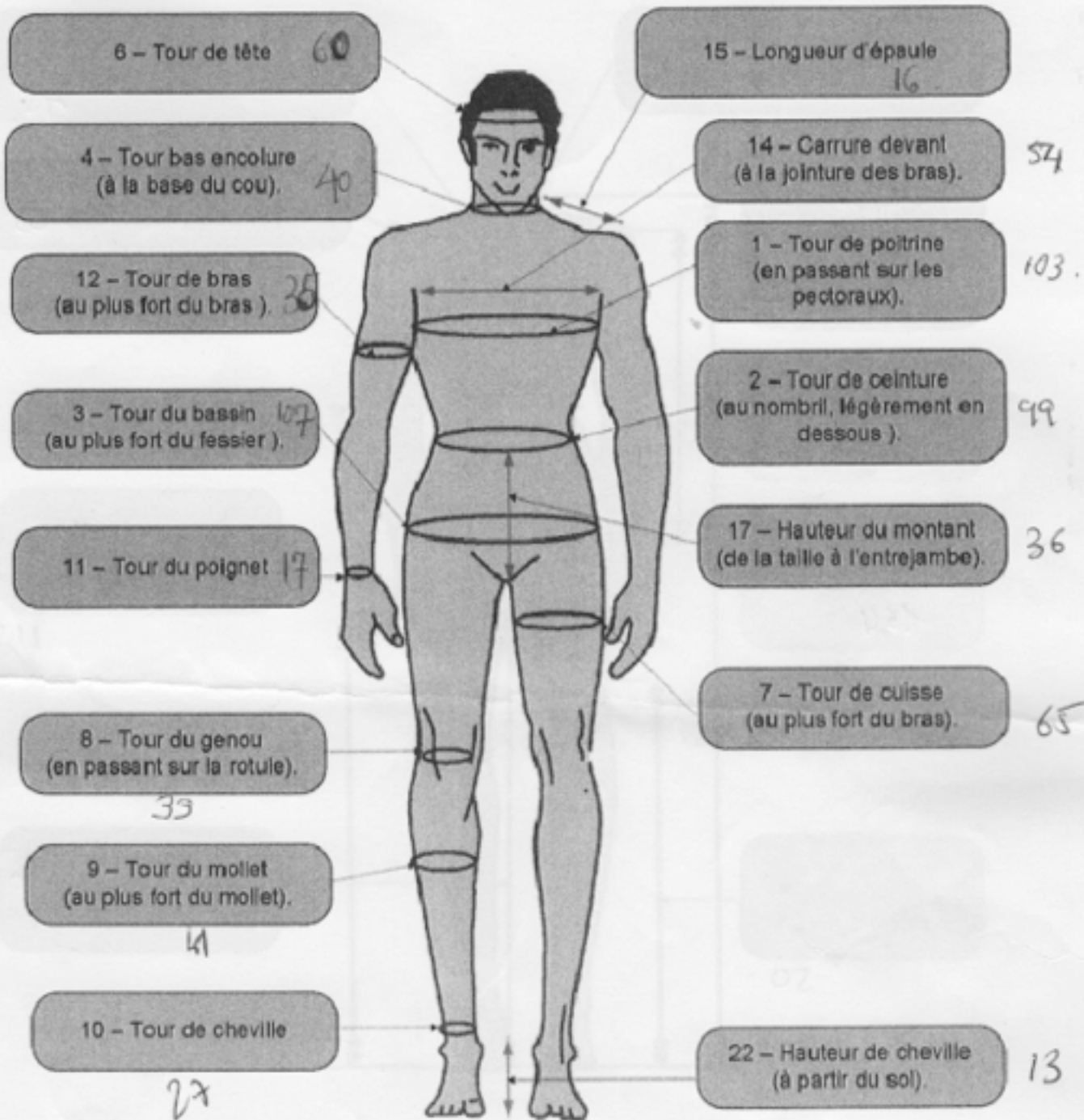
SODIN.

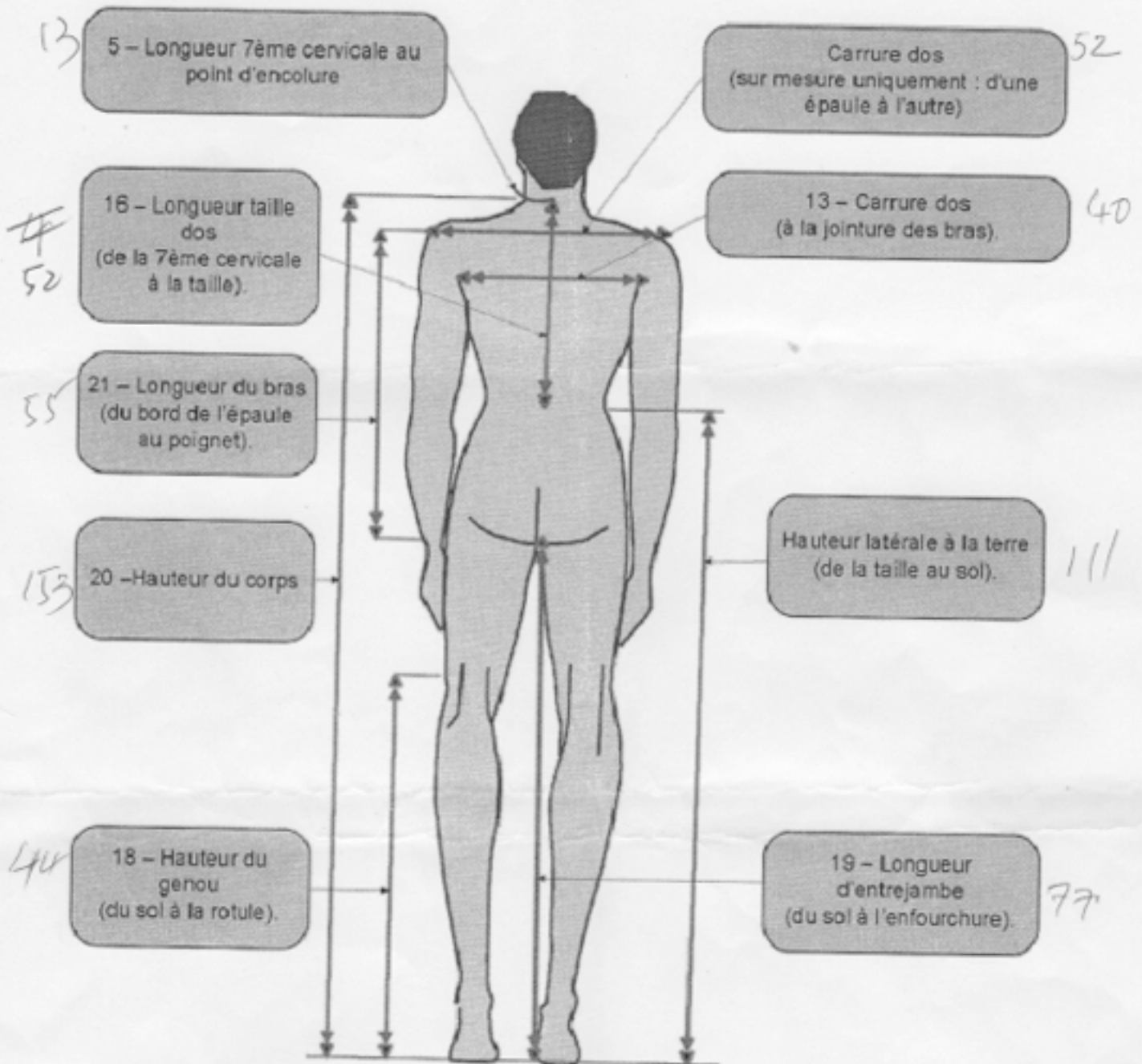
GAVIN

KNOWM



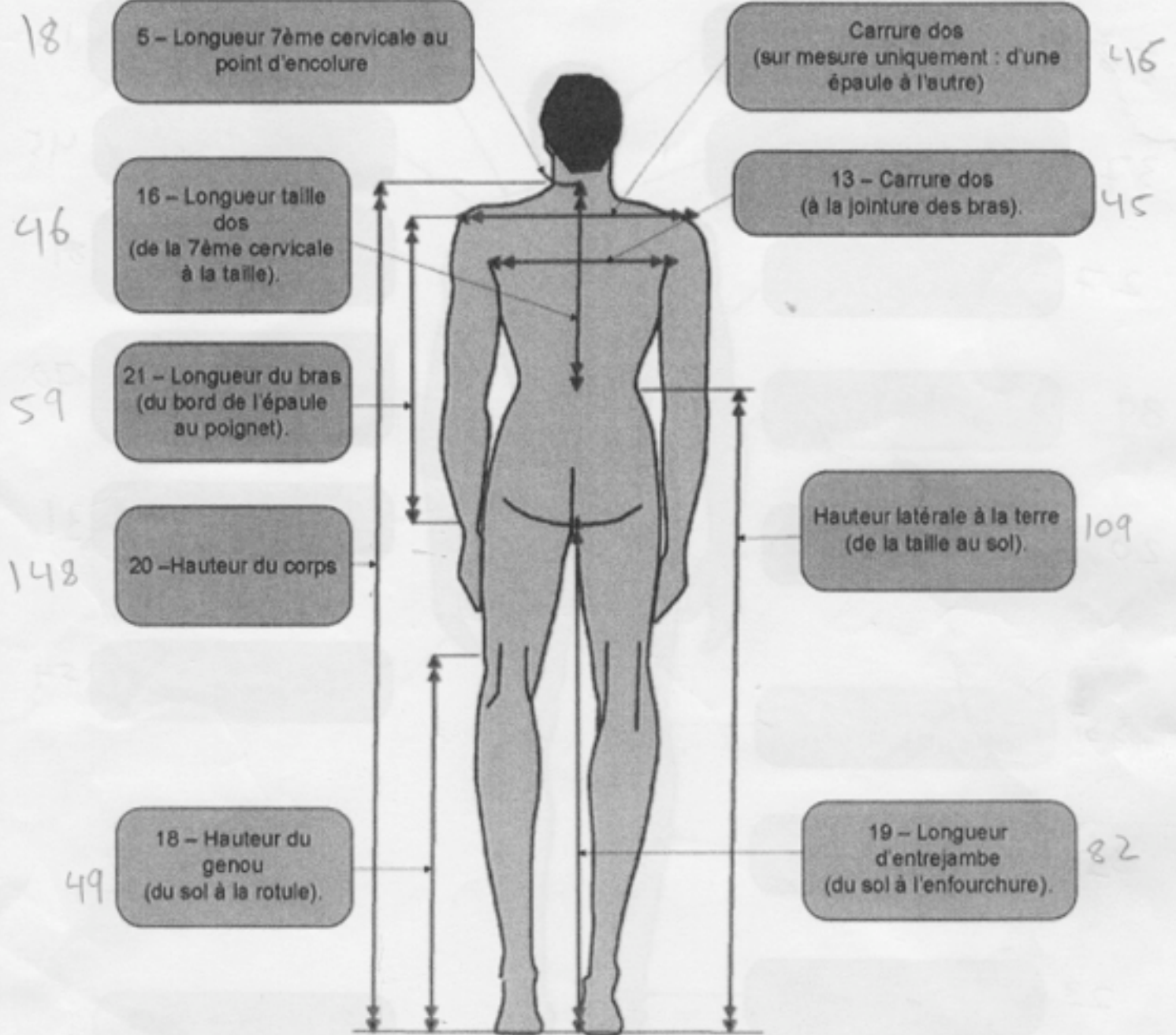












10 -
5 - Longueur 7ème cervicale au point d'encolure

54
Carrure dos
(sur mesure uniquement : d'une épaule à l'autre)

46
16 - Longueur taille dos
(de la 7ème cervicale à la taille).

50
13 - Carrure dos
(à la jointure des bras).

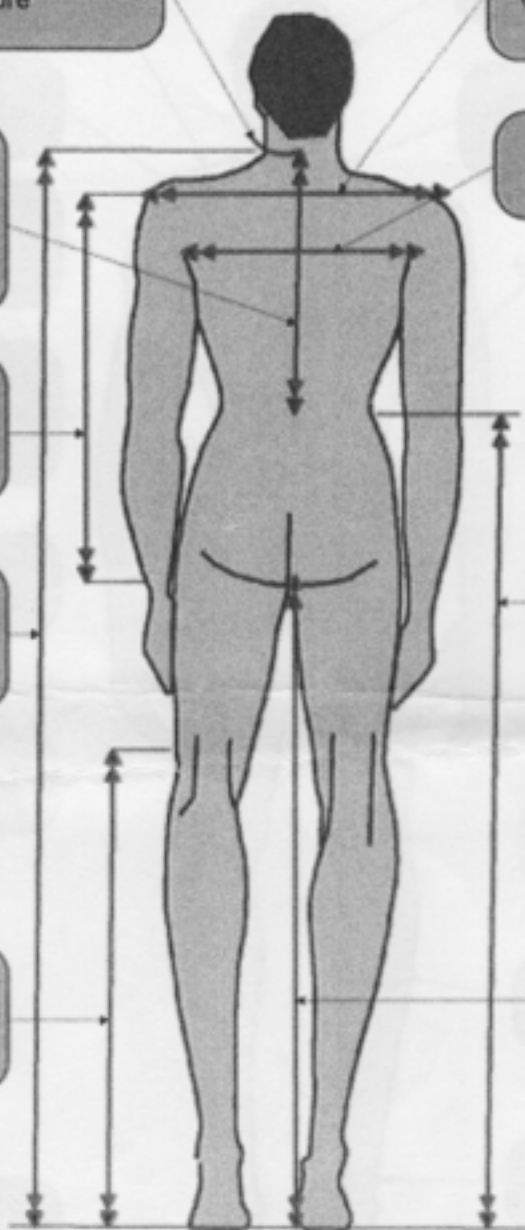
69
21 - Longueur du bras
(du bord de l'épaule au poignet).

152
20 - Hauteur du corps

116
Hauteur latérale à la terre
(de la taille au sol).

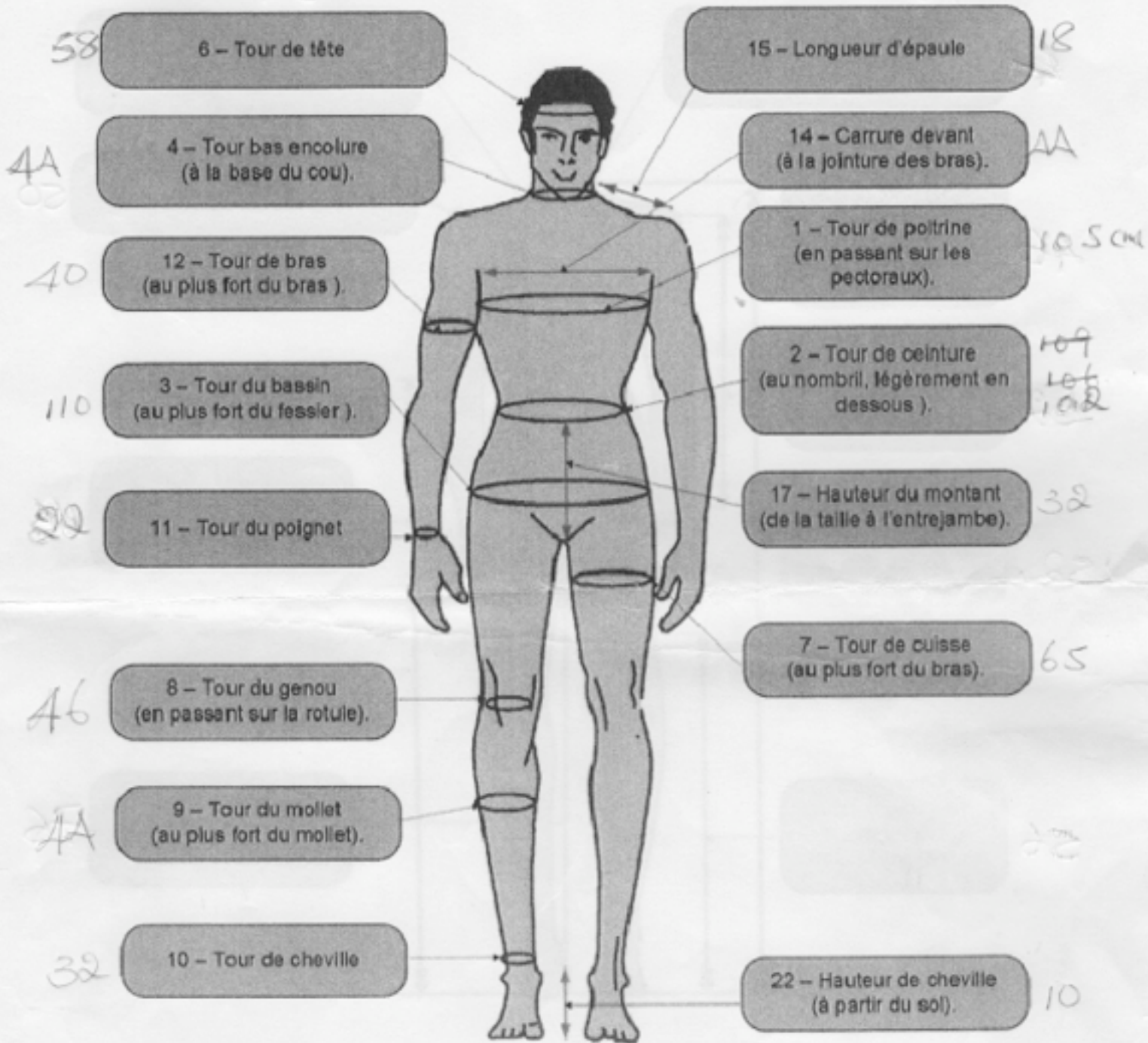
56
18 - Hauteur du genou
(du sol à la rotule).

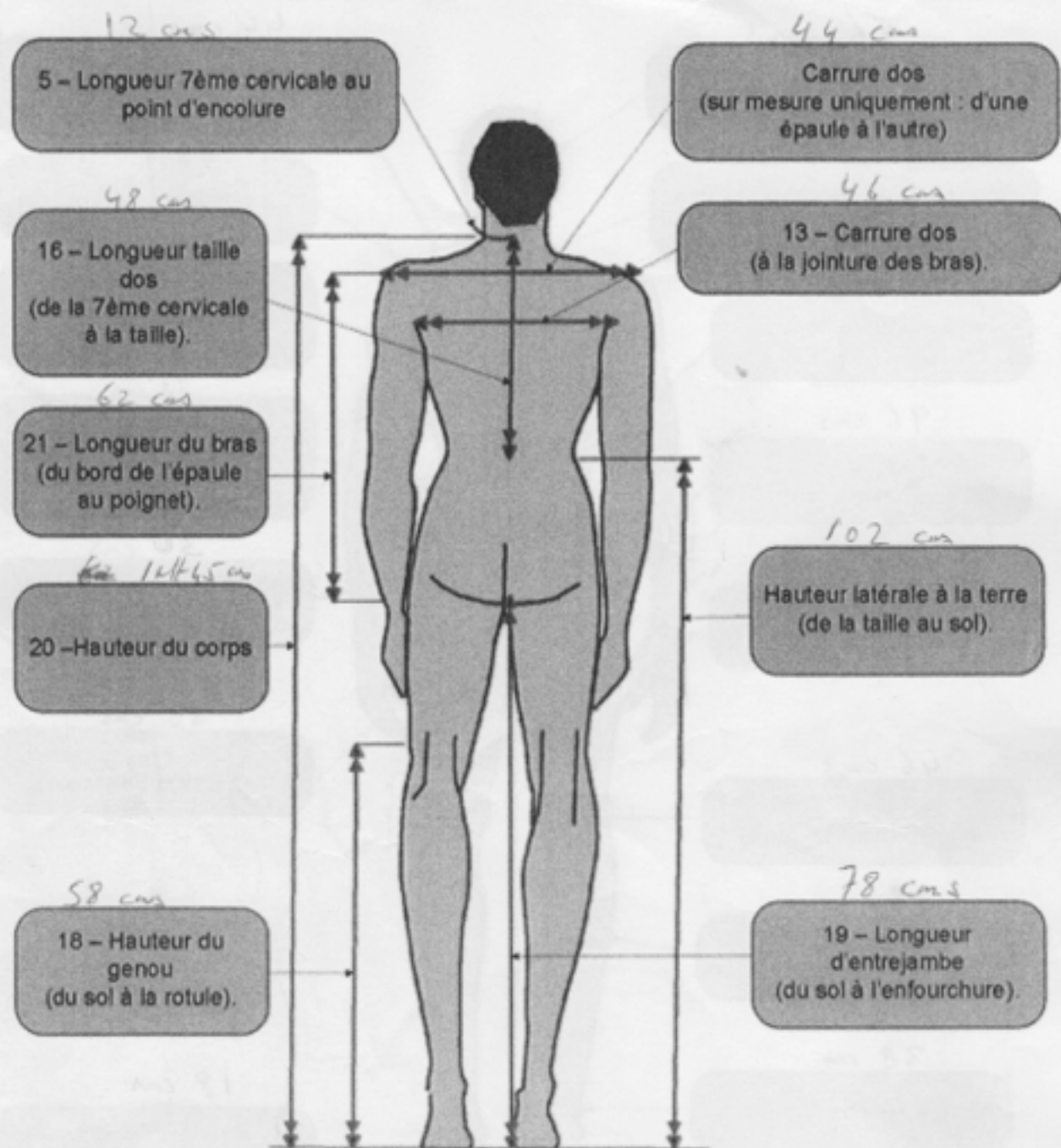
76
19 - Longueur d'entrejambe
(du sol à l'enfourchure).



Vicky Ragoban

(measurement in Cm)





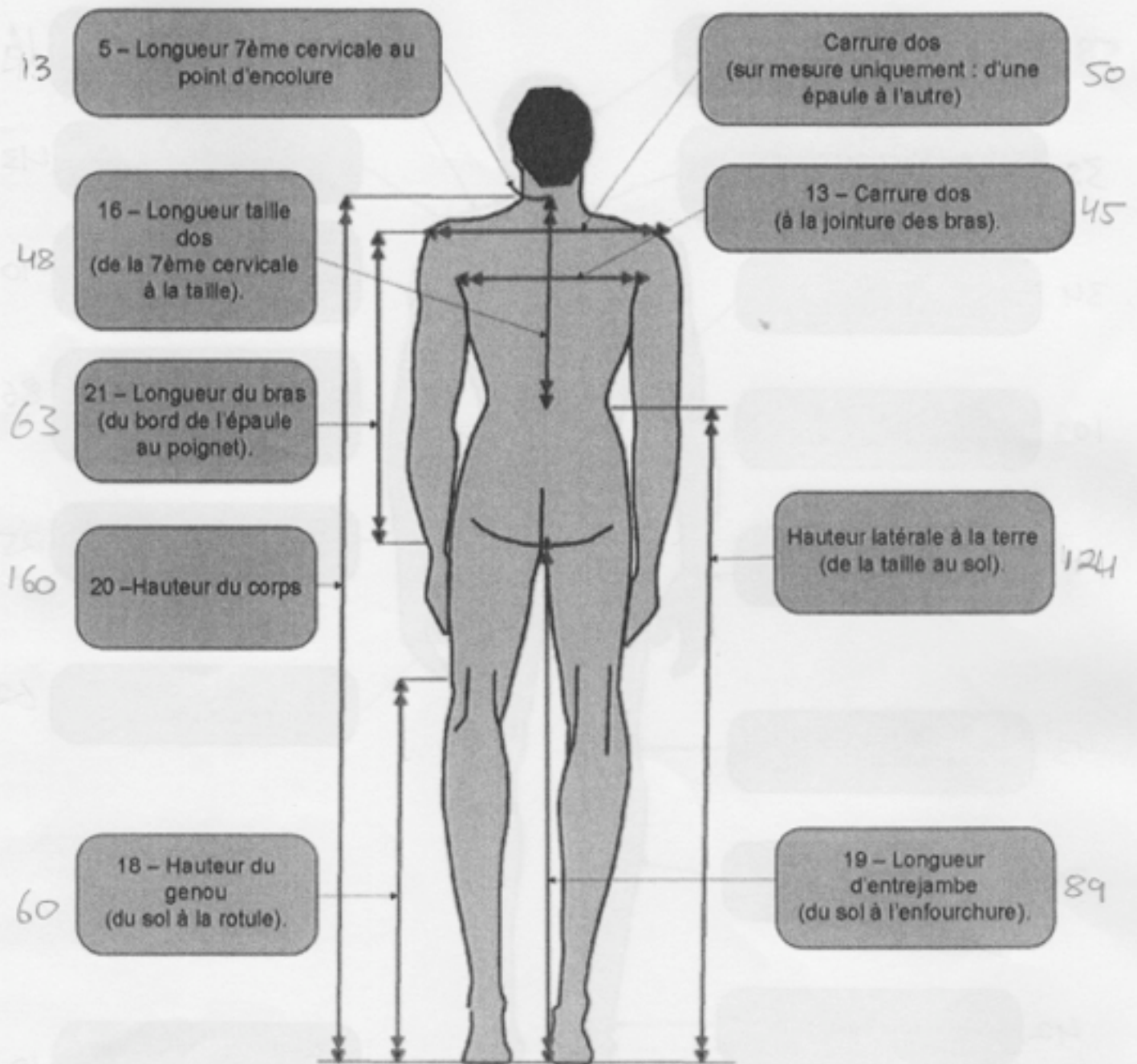
Beekhorst

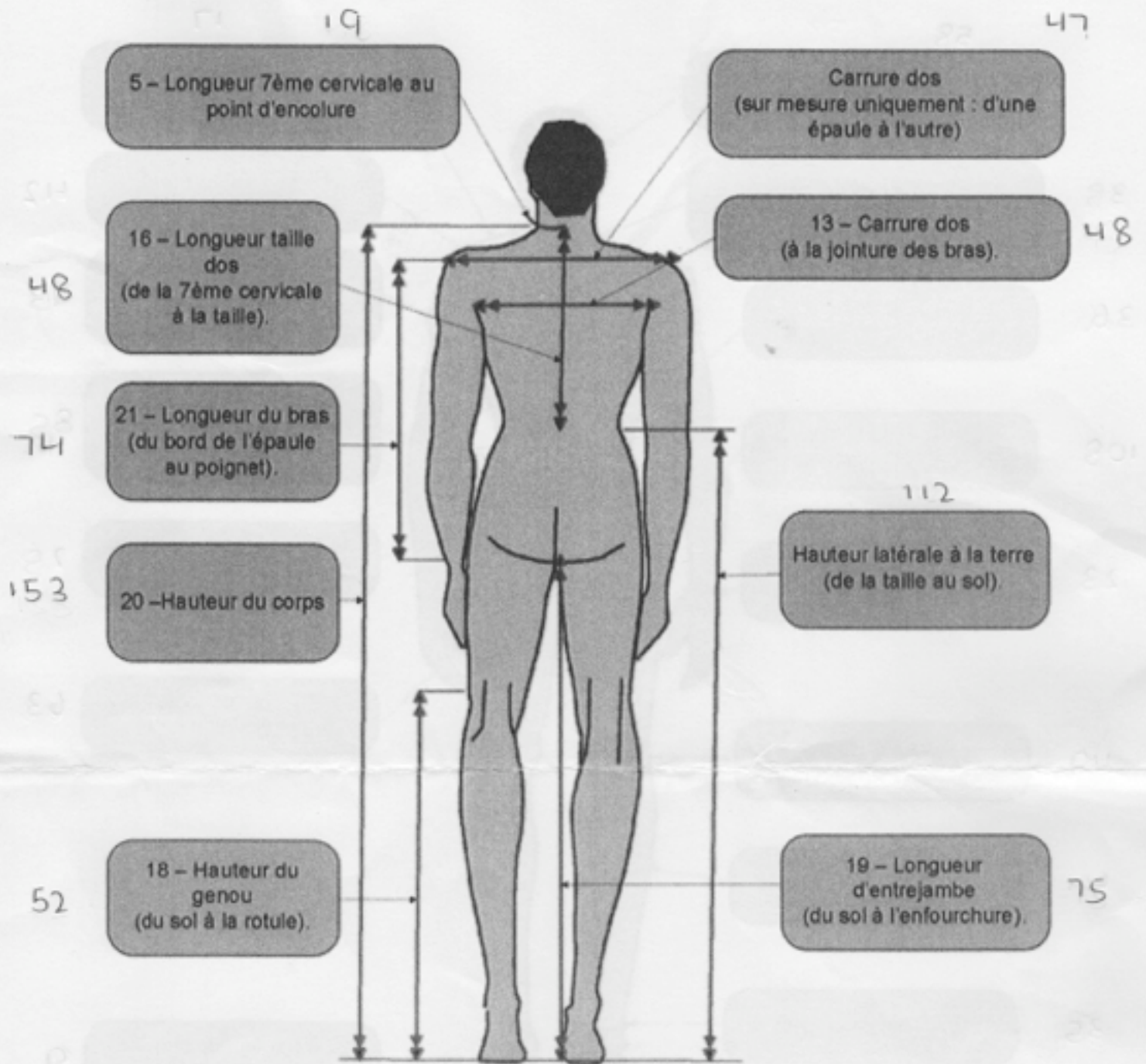
Shameem

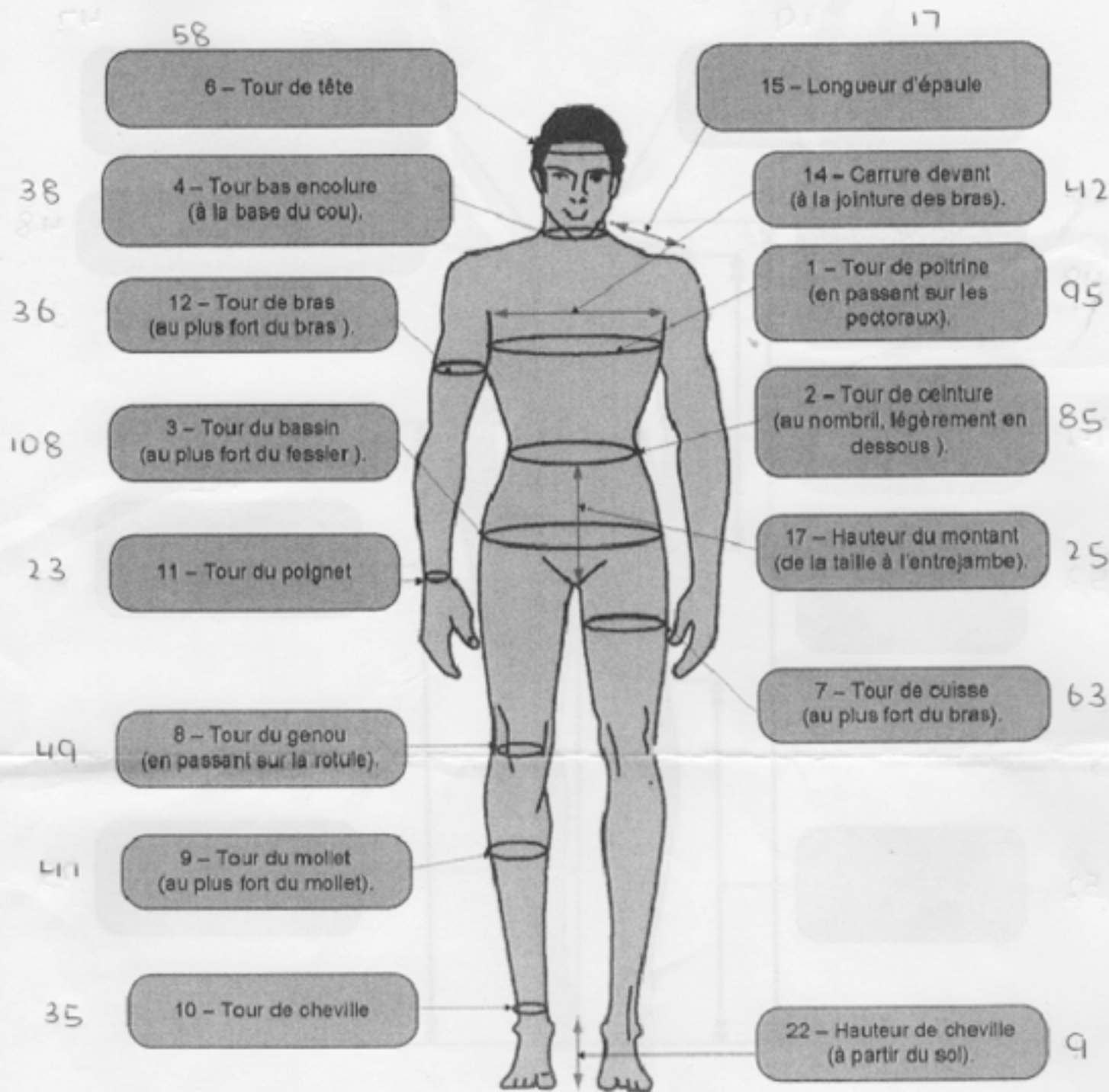


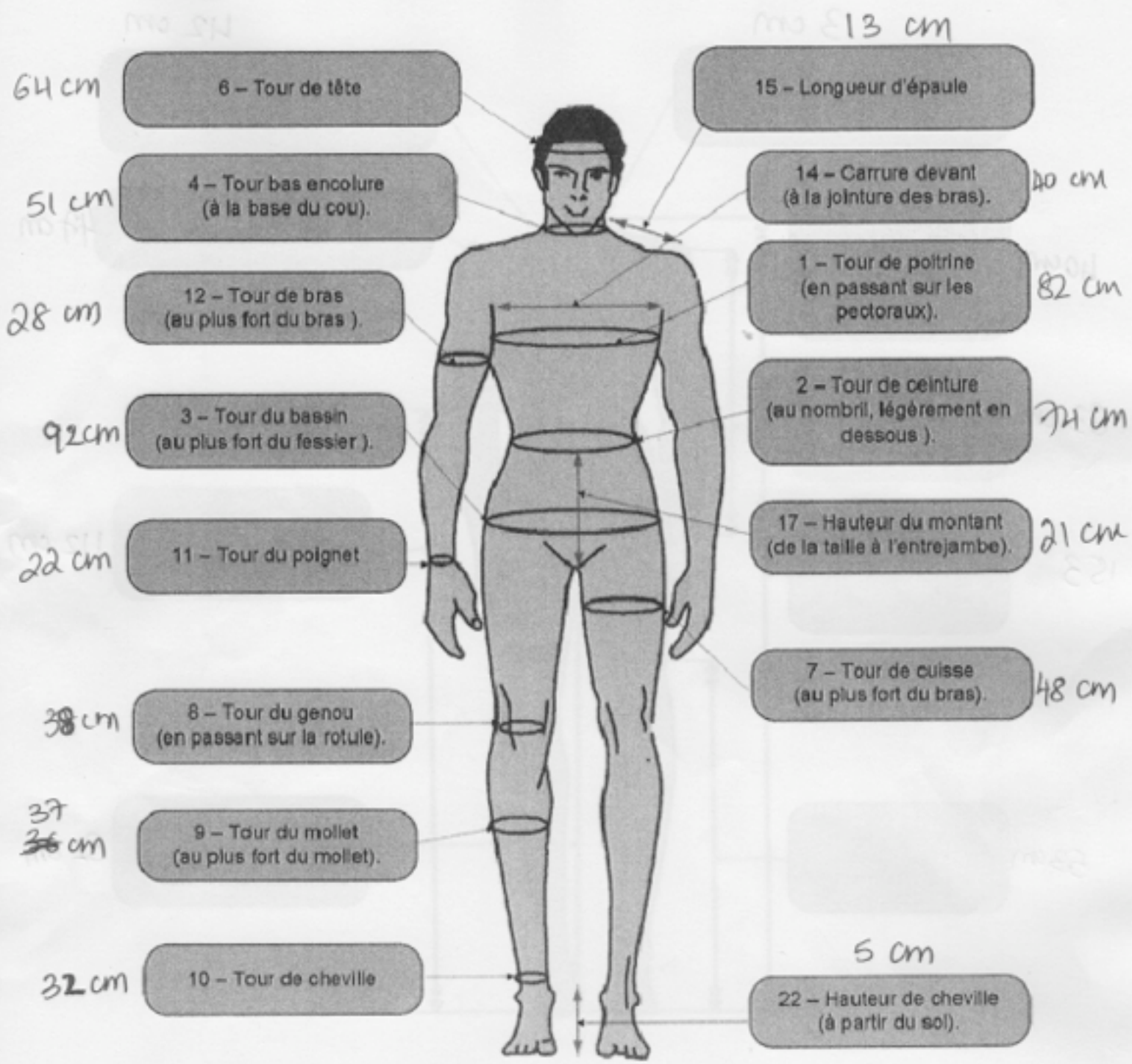
Longueur pantalon = 102 cms



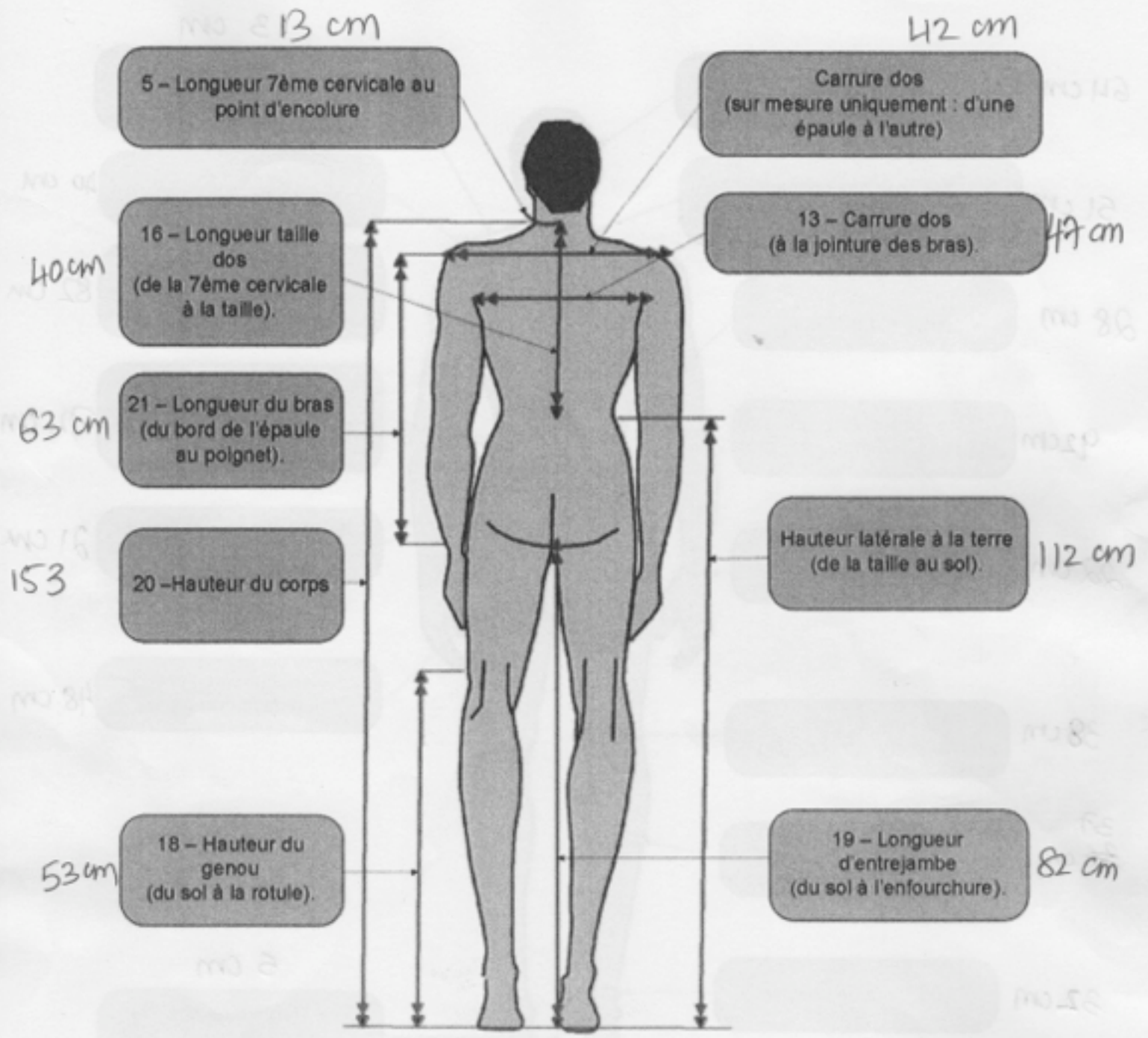








Name: Judith Suhange
Batch 5



Name: Yudich Suhanye
Batch 5

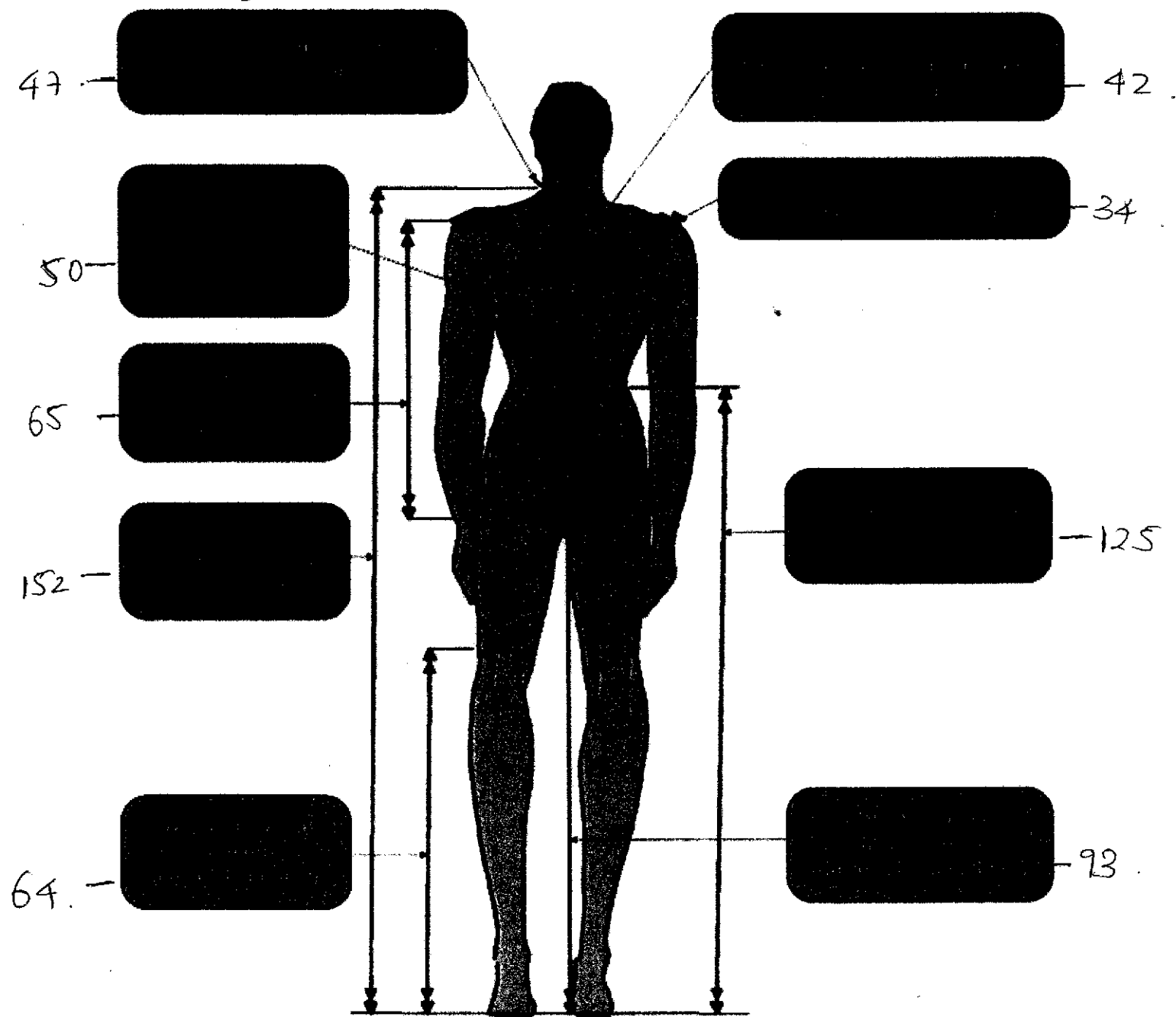
APOLLO BRAMWELL NURSING SCHOOL

SURNAMLE	OTHER NAMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
1 Auckbur	Anne Emilie Lisa	F	120	104	127	119	80	114	31	25	40	44	42	42	46	14	62	36	43	22	109	72	62	105	27	52	75
2 Balchand	Manisha	F	104	94	108	103	27	21	32	22	40	43	41	40	42	18	56	37	36	18	95 95	69	98	39	45	57	
3 Boodhun	Upashna	F	98	93	119	101	28	16	28	18	36	38	48	38	37	11	57	36	34	17	117	83	58 28	26	44	69	
4 Coolen	Mewenavadee	F	96	66	86	82	24	12	24	34	44	44	33	33	32	14	57	30	24	20	100	85	50	38	34	40	42
5 Dinnahamed	Sumaiyah	F	105	115	124	120	23	11	29	22	40	42	44	40	48	18	59	35	40	20	105	87	57	20	26	50	79
6 Dookhurrun	Sanjeena	F	80	69	86	78	19	10	15	14	42	49	32	32	31	13	58	35	22	15	104	86	61	50	24	35	47
7 Duval	Marie Julietta Nadine	F	83	72	99	87	28	16	24	12	33	29	33	33	37	14	56	35	30	16	109	89	67	67	22	40	55
8 Fokeer	Shiksha Chivance	F	102	87	105	108	27	15	28	26	37	45	46	36	36	10	53	33	34	18	95	64	58	59	23	38	54
9 Hanooman	Ashwinee	F	115	104	110	122	29	12	34	36	38	55	43	42	42	20	68	42	32	24	119	101	72	82	28	50	72
10 Khodabux	Amirrah Bibi	F	72	63	85	78	23	11	20	28	40	33	33	35	32	11	56	34	21	15	104	81	53	44	20	33	44
11 Kurrooman	Shandisha Devi	F	77	89	89	79	18	7	23	15	42	37	35	27	35	12	55	31	25	19	93	82	56	48	26	36	48
12 Nahaboo Solim	Hanaa	F	81	71	93	86	23	15	23	18	36	36	36	38	32	13	53	33	23	16	99	76	55	38	21	33	47
13 Pargass	Sounitradevi	F																									
14 Pernal	Beija Only	F	94	80	105	94	25	10	30	20	34	40	34	36	36	13	58	34	31	17	108	78	64	73	24	38	63
15 Rangoolam	Vijayaluxmi	F	41	34	95 95	45 91	25	13	23	82	34	32	40	42	35	12	47	29	30	18	99	75	50	26	27	38	54
16 Silavente	Julia	F	126	113	116	117	30	10	35	8	60	47	64	46	43	17	60	37	32	22	114	78	60	30	31	50	70

APOLLO BRAMWELL NURSING SCHOOL

SURNAME	OTHER NAMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Beekhory	Muhammad Shameem	84	78	96	38	12	56	56	46	38	38	26	28	46	40	44	48	30	58	78	145	62	18	44	102
Bucha	Keshwan Kritama	84	74	92	36	42	56	52	34	38	30	14	22	34	32	20	50	36	64	93	152	65	10	42	125
Dwarika	Maheshav	95	85	108	38	19	58	63	49	41	35	23	36	48	42	17	48	25	52	75	153	74	9	47	112
Fatally	Abou Bakar Sidick	85	80	89	36	13	54	49	35	34	24	15	28	40	40	16	52	29	44	72	153	55	12	52	111
Goolam Mamode	Luqmaan																								
Jugmohun	Keshav	92	94	95	40	10	56	57	44	38	27	21	32	40	41	16	45	34	54	79	150	64	15		112
Khoyraty	Noorani	103	99	107	40	14	60	65	39	41	27	17	35	55	54	16	44	36	50	80	164	60	13	45	115
Lallbeeharry	Insuduth Chris	104	89	106	40	10	58	62	42	39	24	18	35	39	41	12	44	34	53	91	160	67	11	39	117
Mohabul	Ishaie	80	93	90	38	44	58	49	36	36	28	18	25	31	32	16	44	34	52	84	139	54	10	36	101
Mungur	Parveshsing	90	86	102	38	13	58	62	43	39	42	14	34	45	43	16	48	25	60	89	160	63	10	50	124
Padaruth	Kevin	89	70	89	37	18	58	54	35	35	23	20	27	45	45	13	46	31	49	82	148	59	9	45	109
Ragoobar	Laval Vicky	105	102	110	44	10	58	65	46	44	32	22	40	50	44	18	46	32	56	76	152	62	10	54	116
Soodin	Samsoundar Gavin	107	103	109	43	54	60	62	42	42	30	20	39	44	41	19	47	27	50	80	152	59	10	56	105
Suharye	Yudish	82	74	92	51	13	64	48	38	37	32	22	28	47	40	13	40	21	53	82	153	63	5	42	112

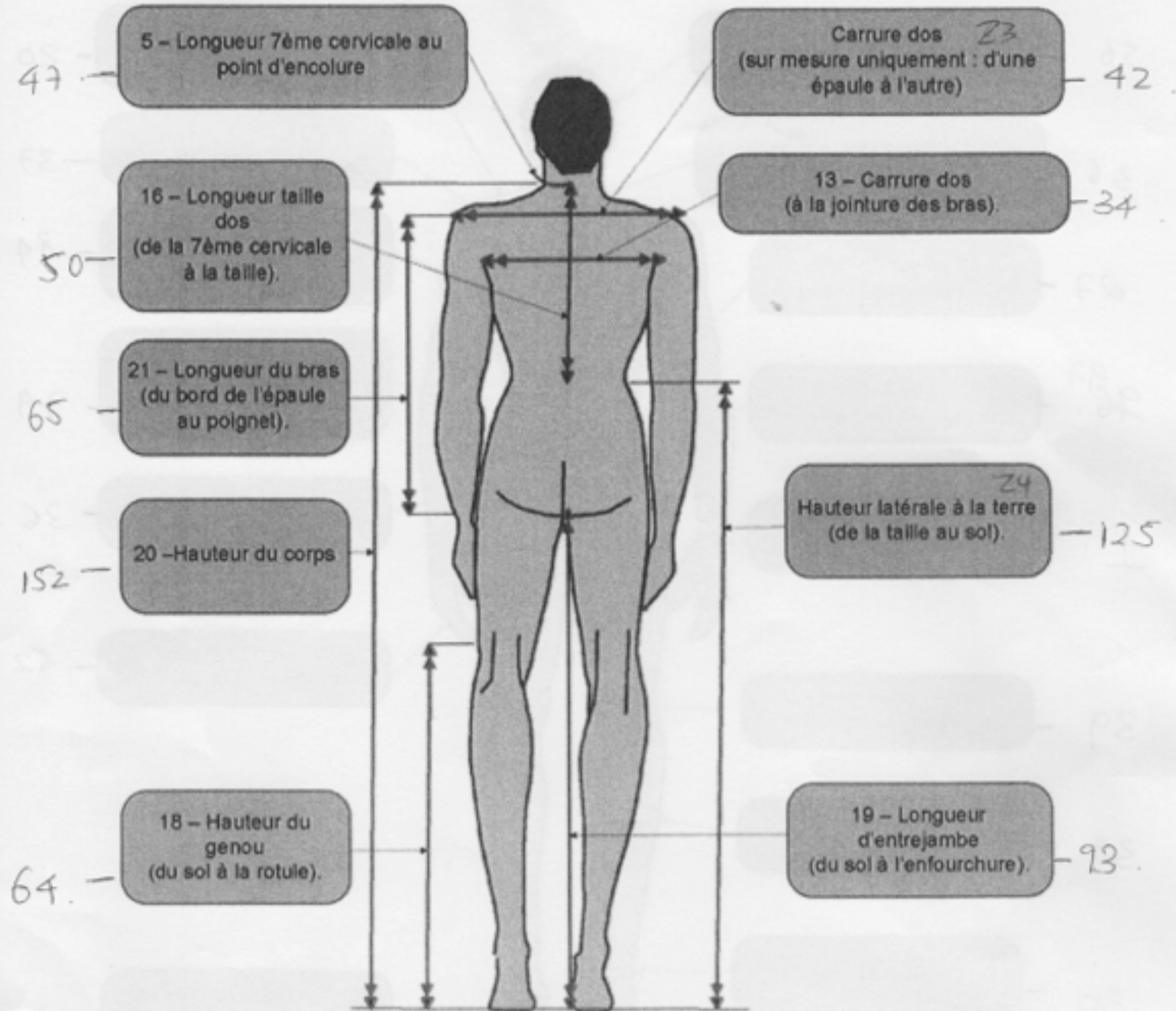
Belt



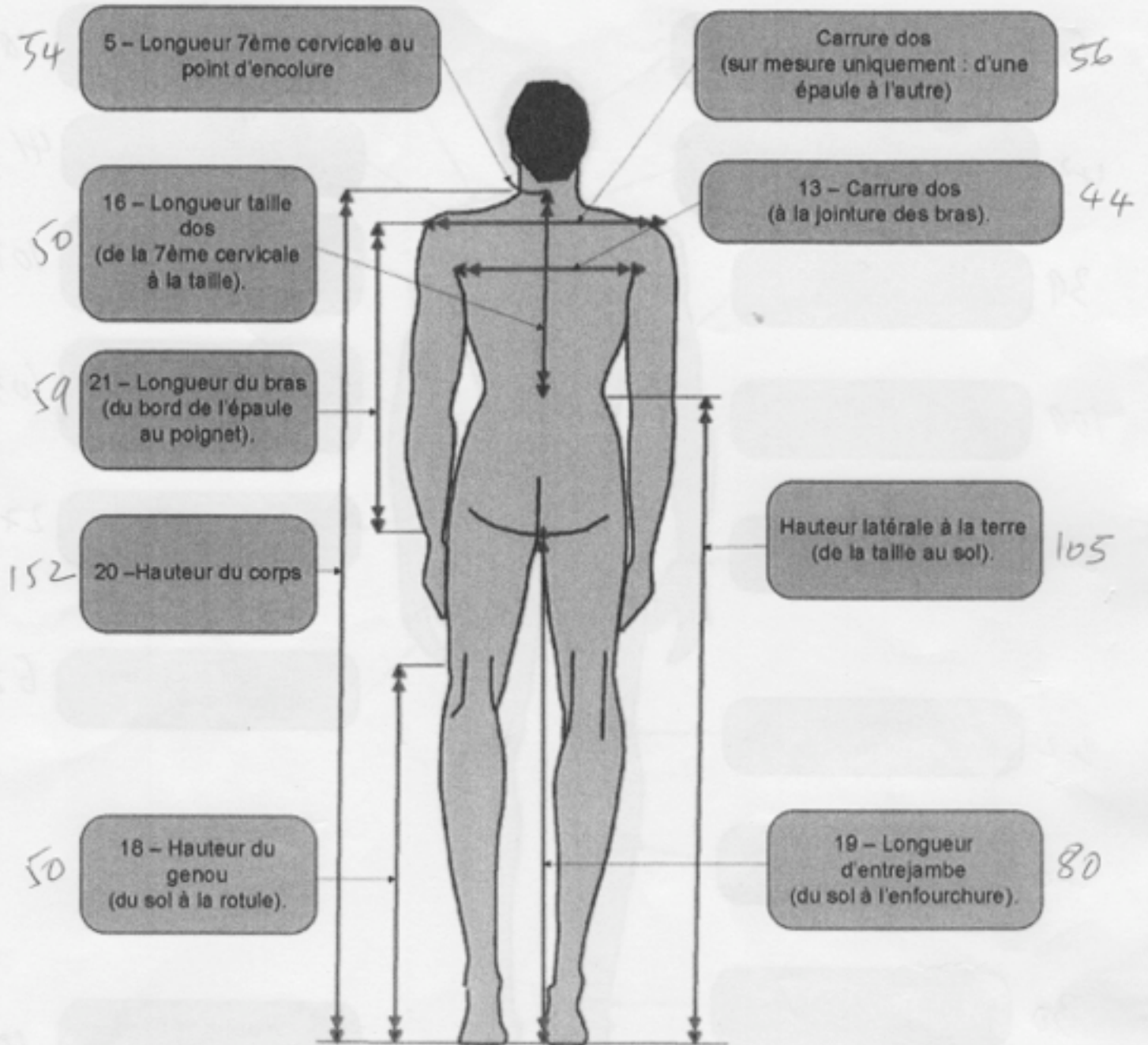
Keshwan

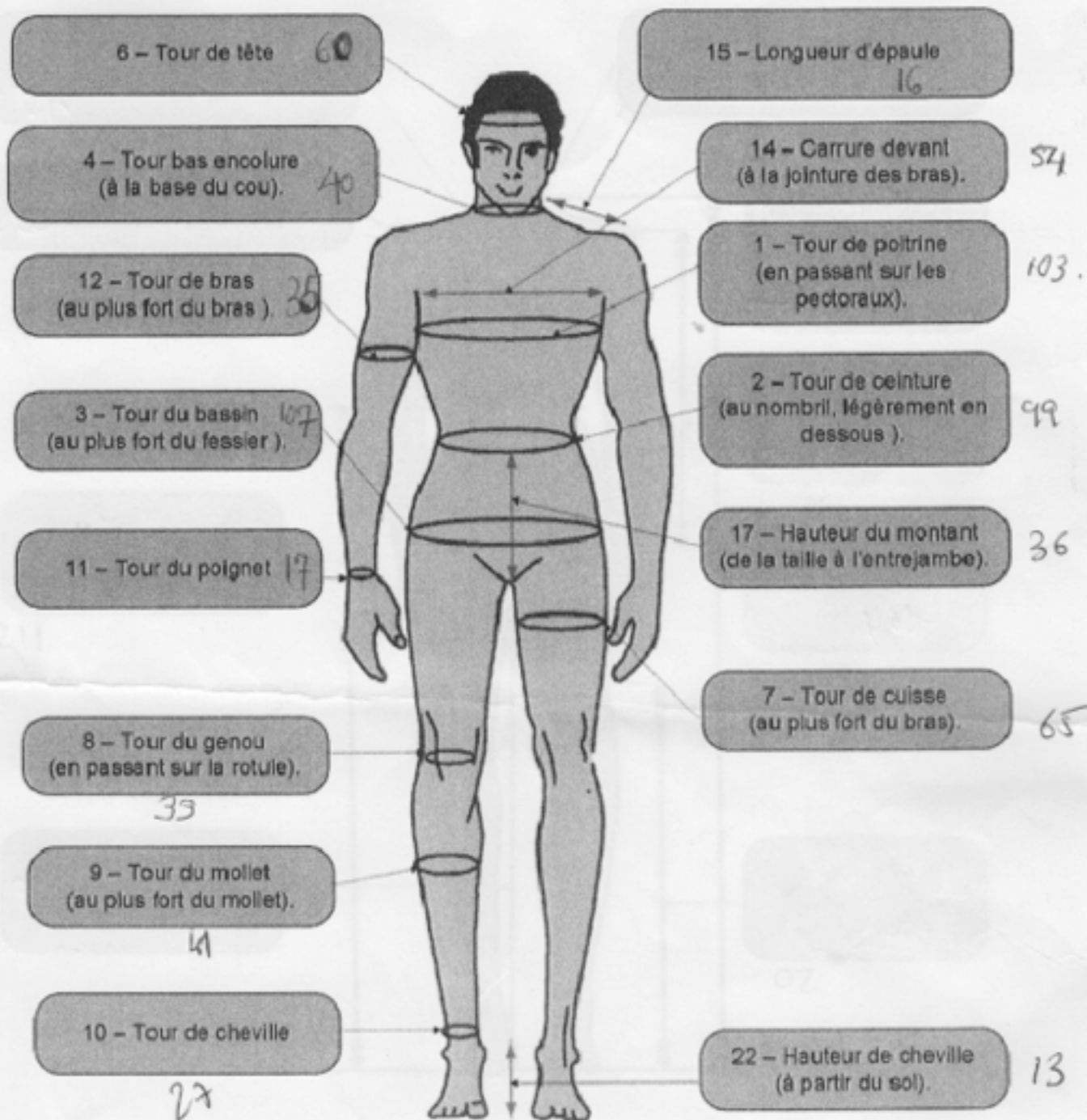


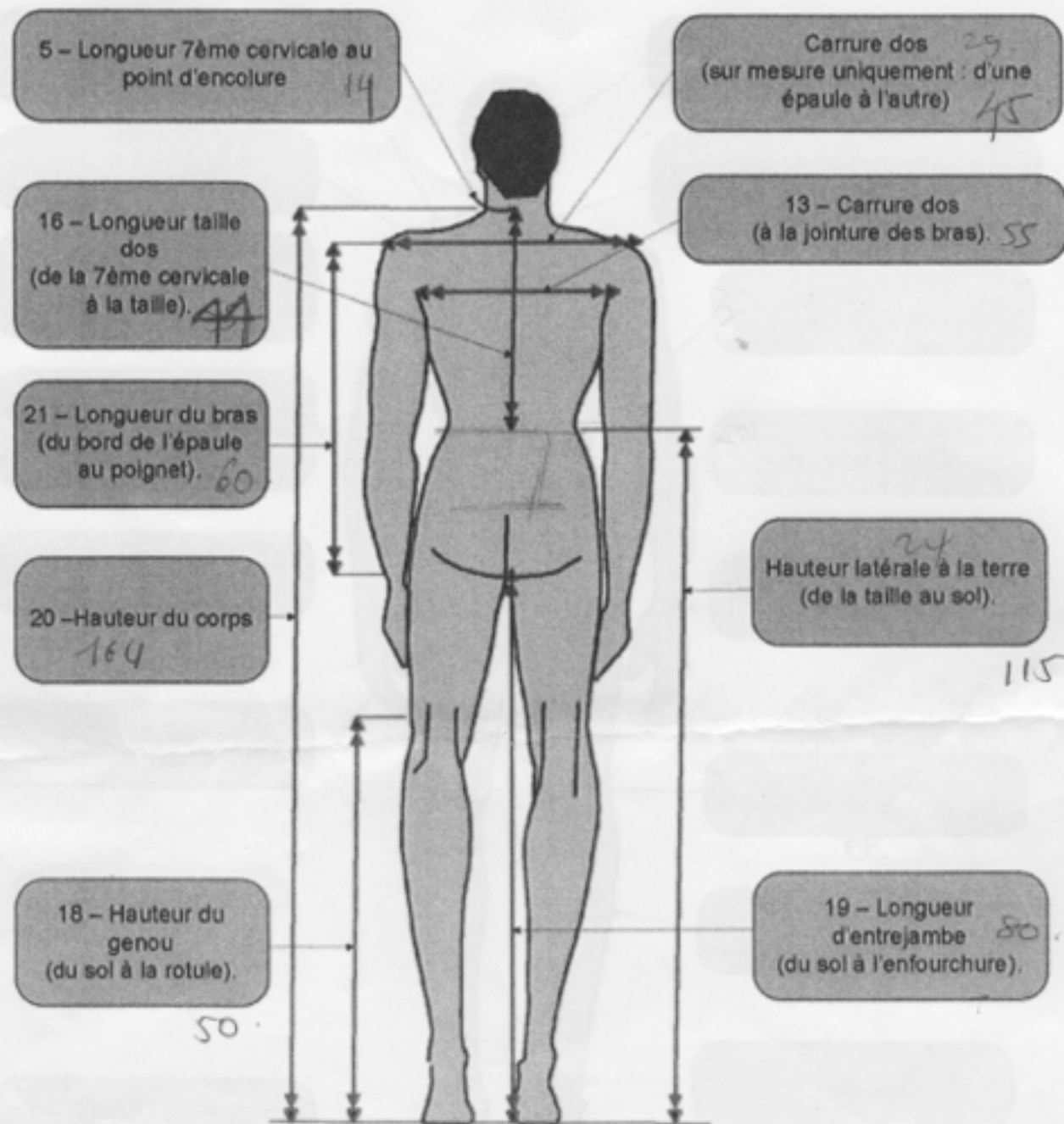
Belle











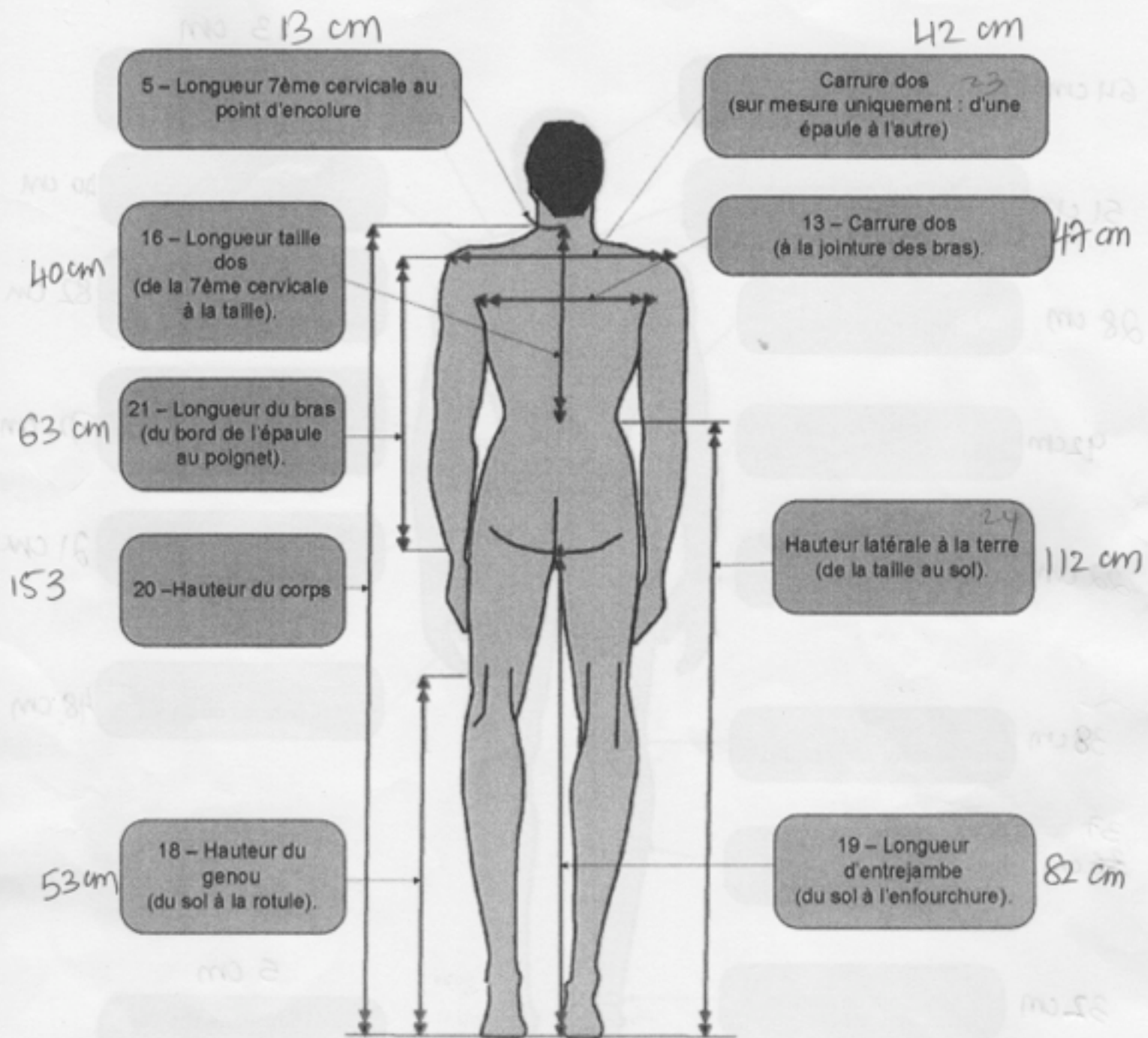
ms 54

ms 13 cm



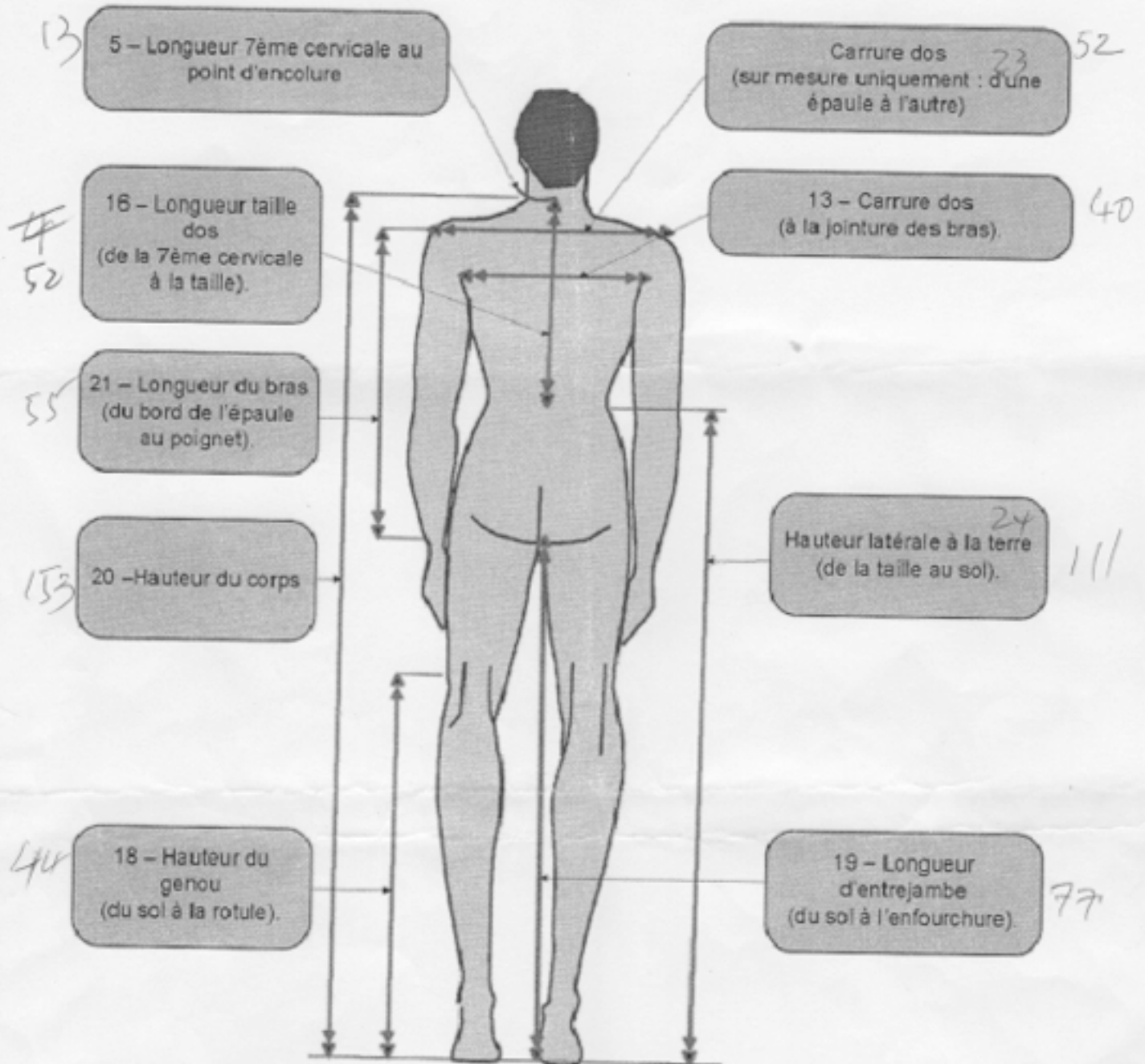
Name: Yudish Suhange
Batch 5

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Batch 5

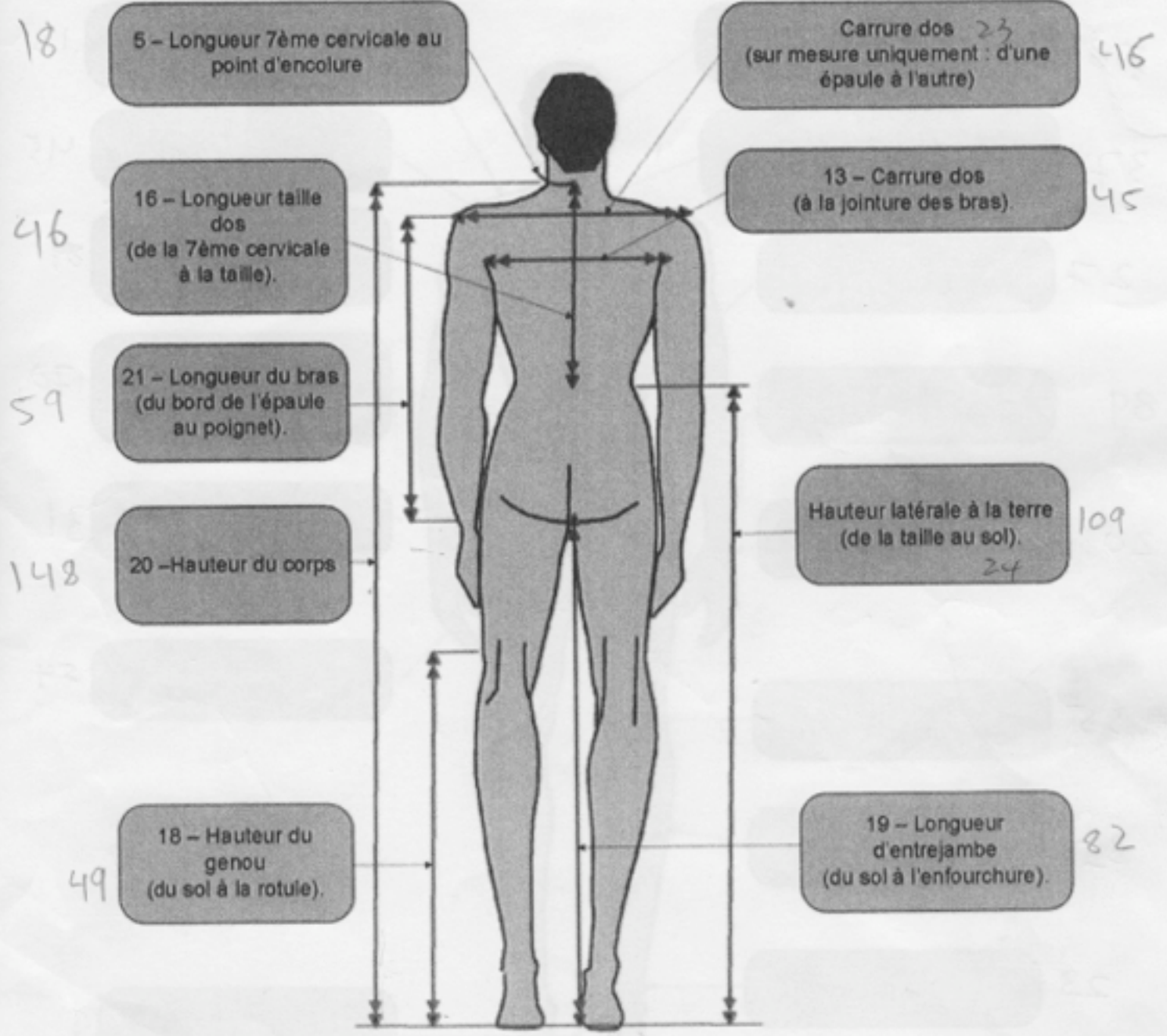


Name: Yudich Suhanye
Batch 5



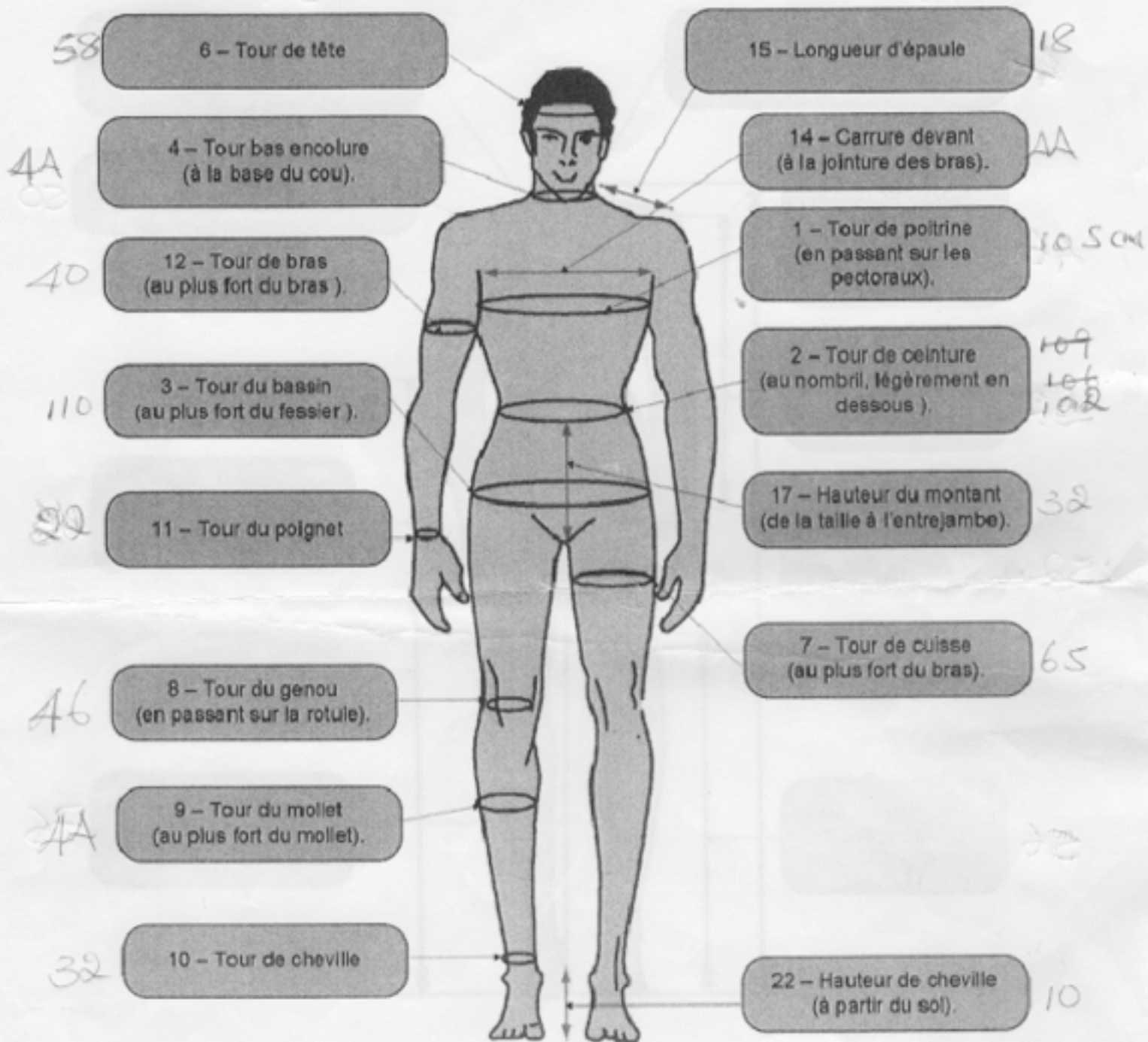






Vicky Ragoban

(measurement in
Cm)



10 -
5 - Longueur 7ème cervicale au point d'encolure

54
Carrure dos 23
(sur mesure uniquement : d'une épaule à l'autre)

46
16 - Longueur taille dos
(de la 7ème cervicale à la taille).

13 - Carrure dos
(à la jointure des bras).

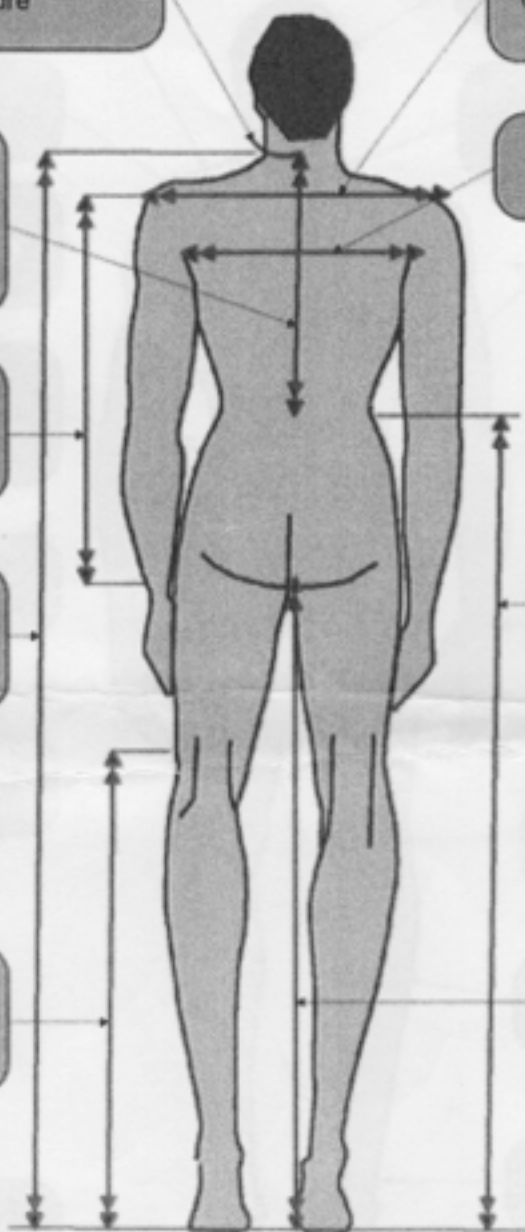
21 - Longueur du bras
(du bord de l'épaule au poignet).

20 - Hauteur du corps

24
Hauteur latérale à la terre
(de la taille au sol).

56
18 - Hauteur du genou
(du sol à la rotule).

76
19 - Longueur d'entrejambe
(du sol à l'enfourchure).

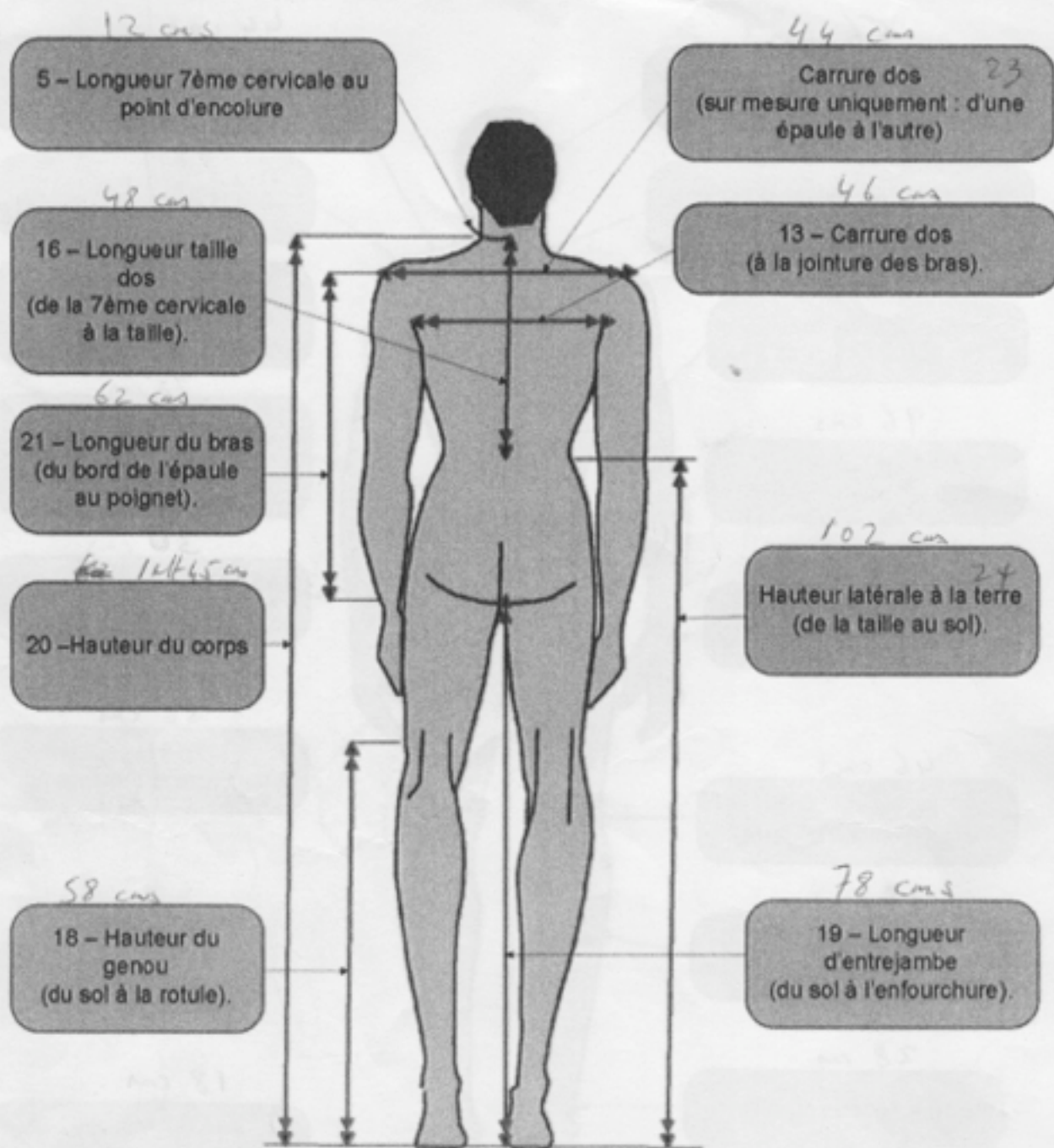


Beekhorst

Shameem

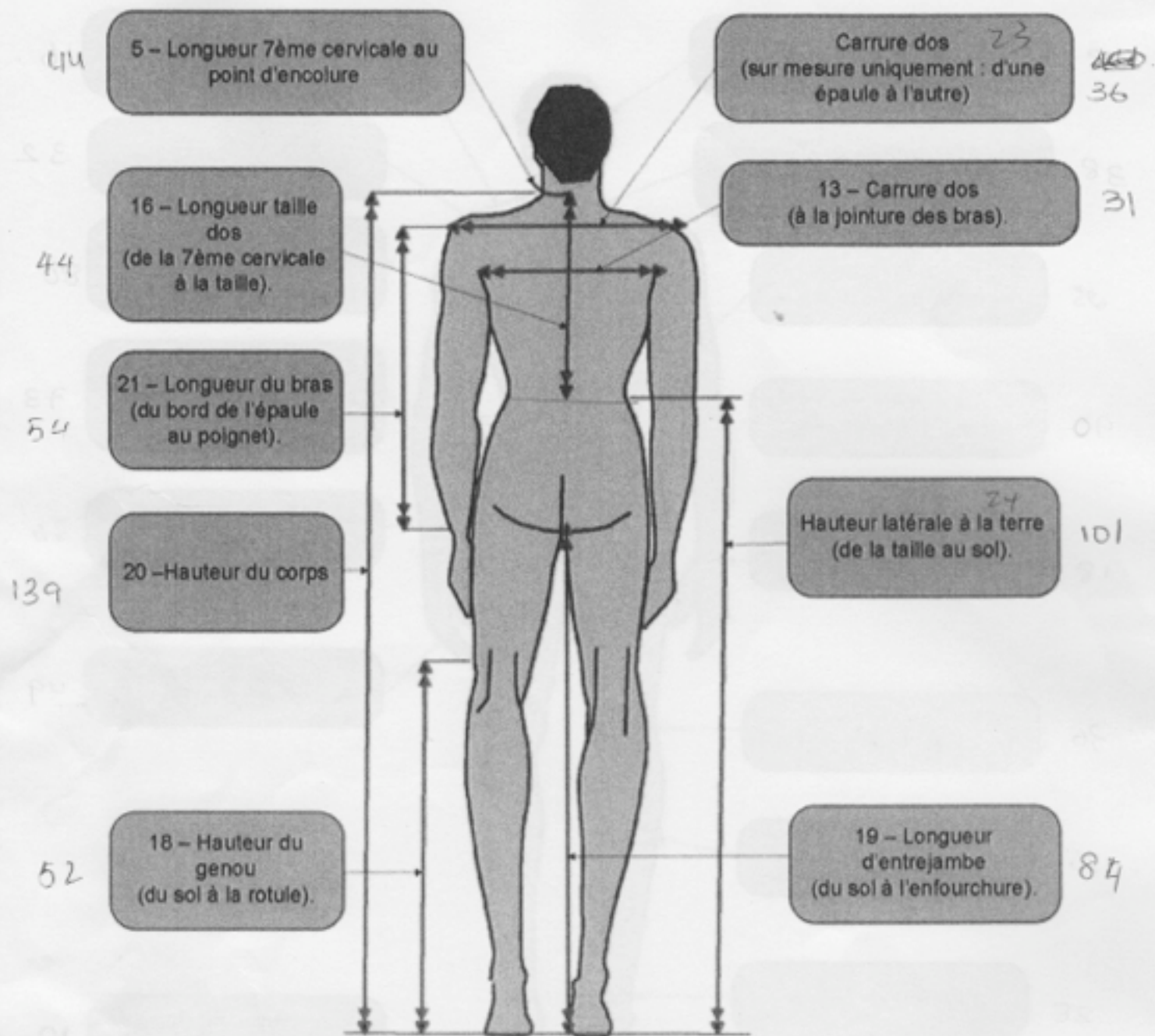


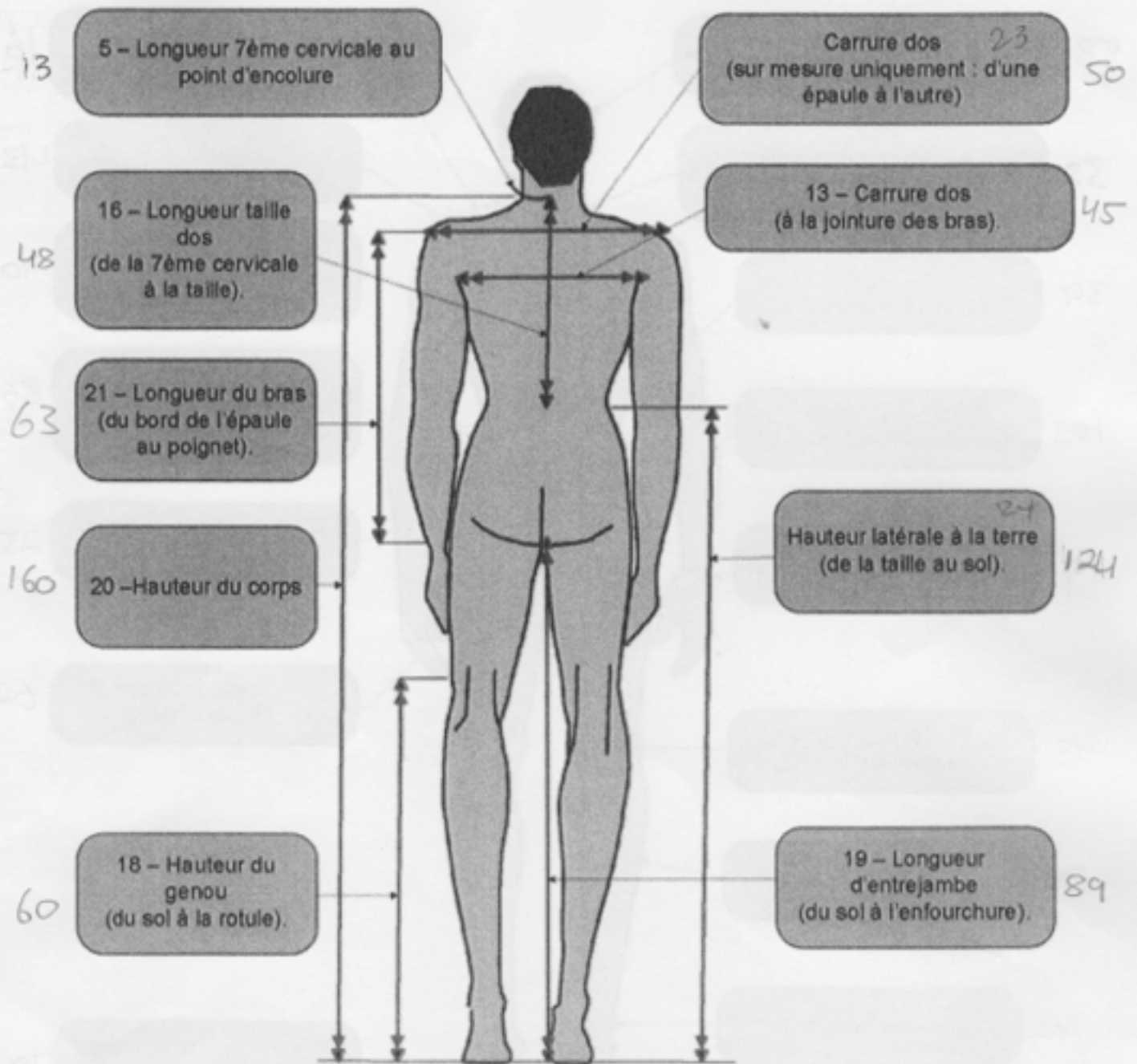
Longueur pantalon = 102 cms



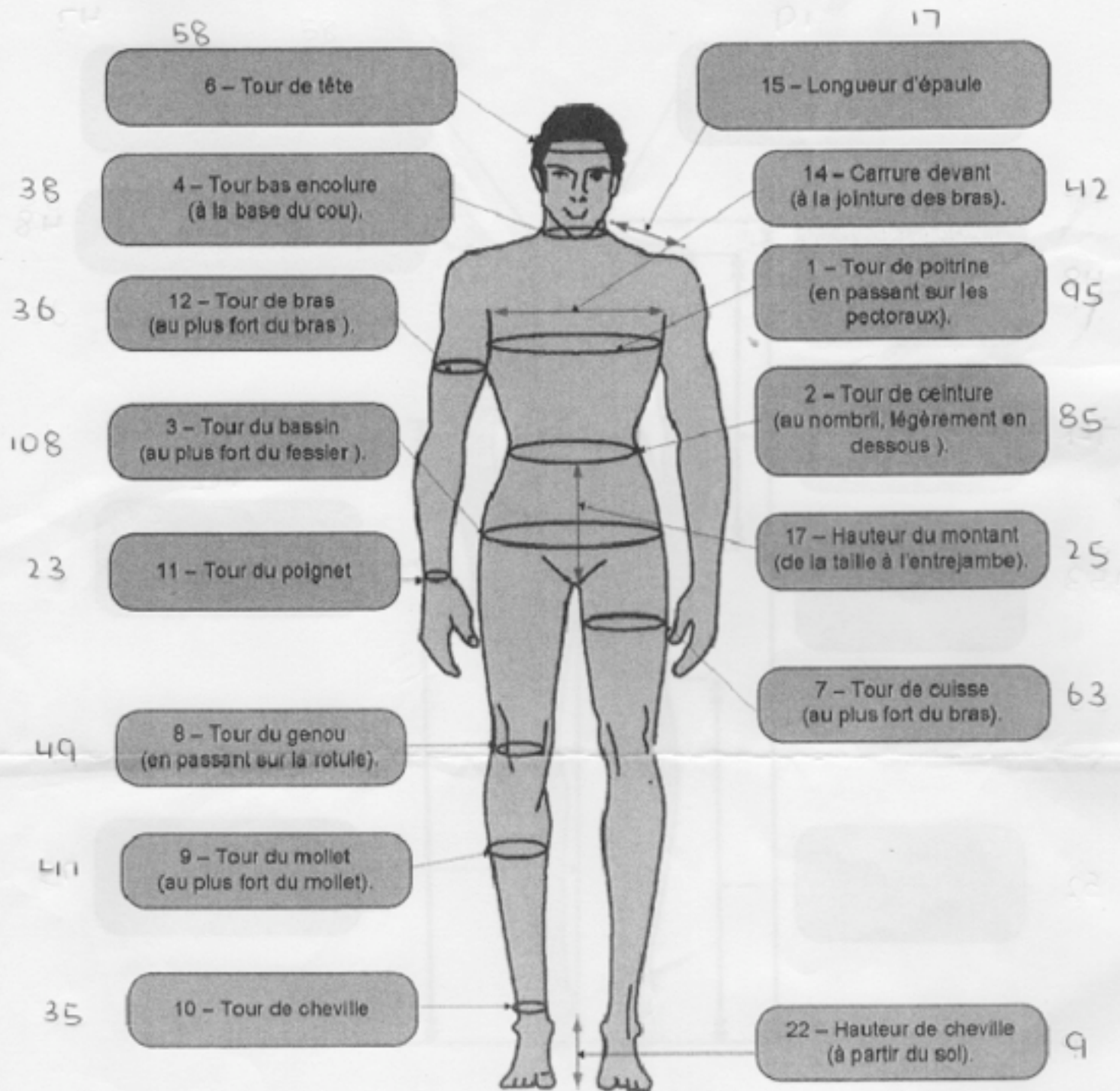
Ishaie

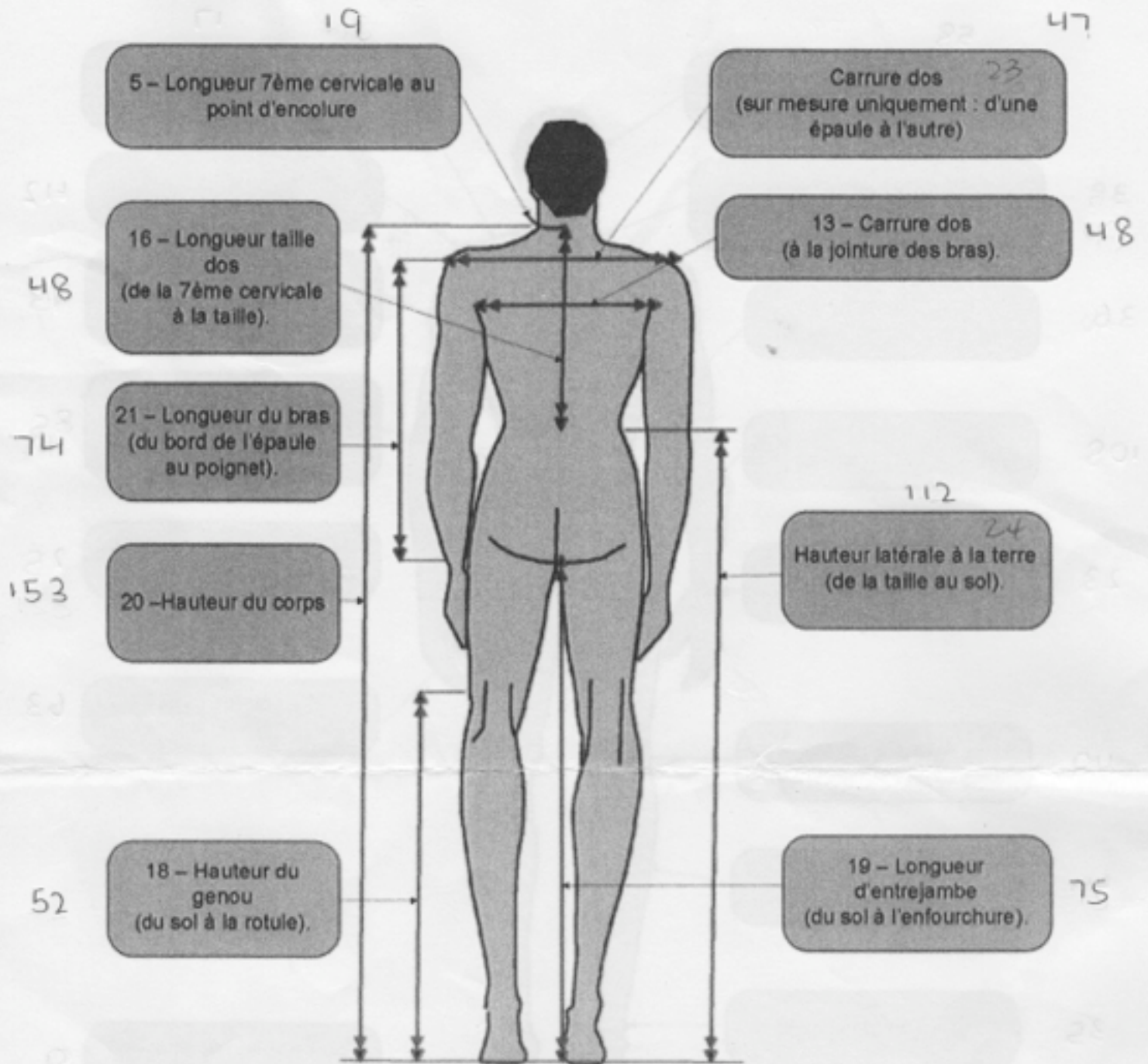








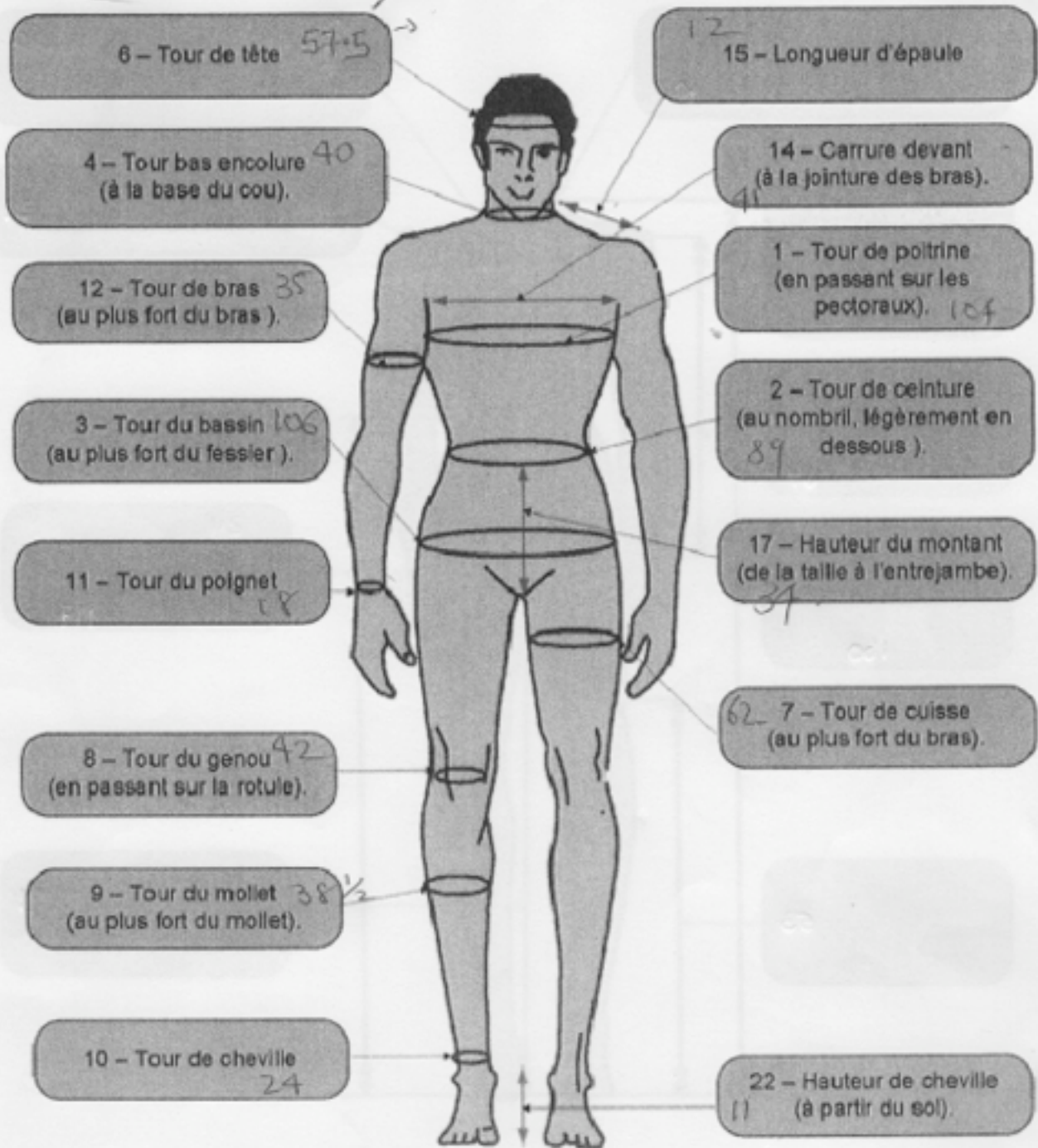




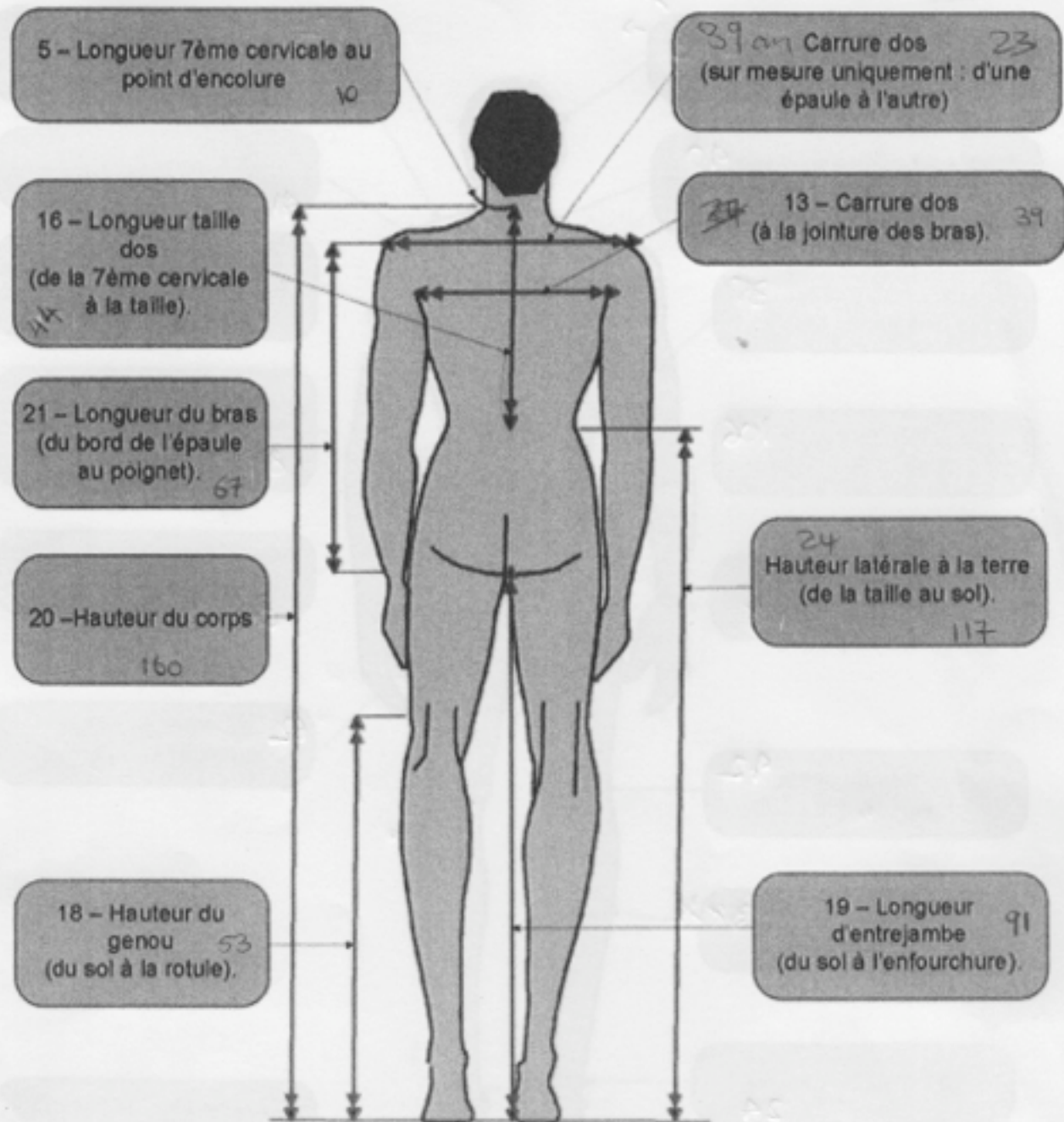
DWARIKA NAMK

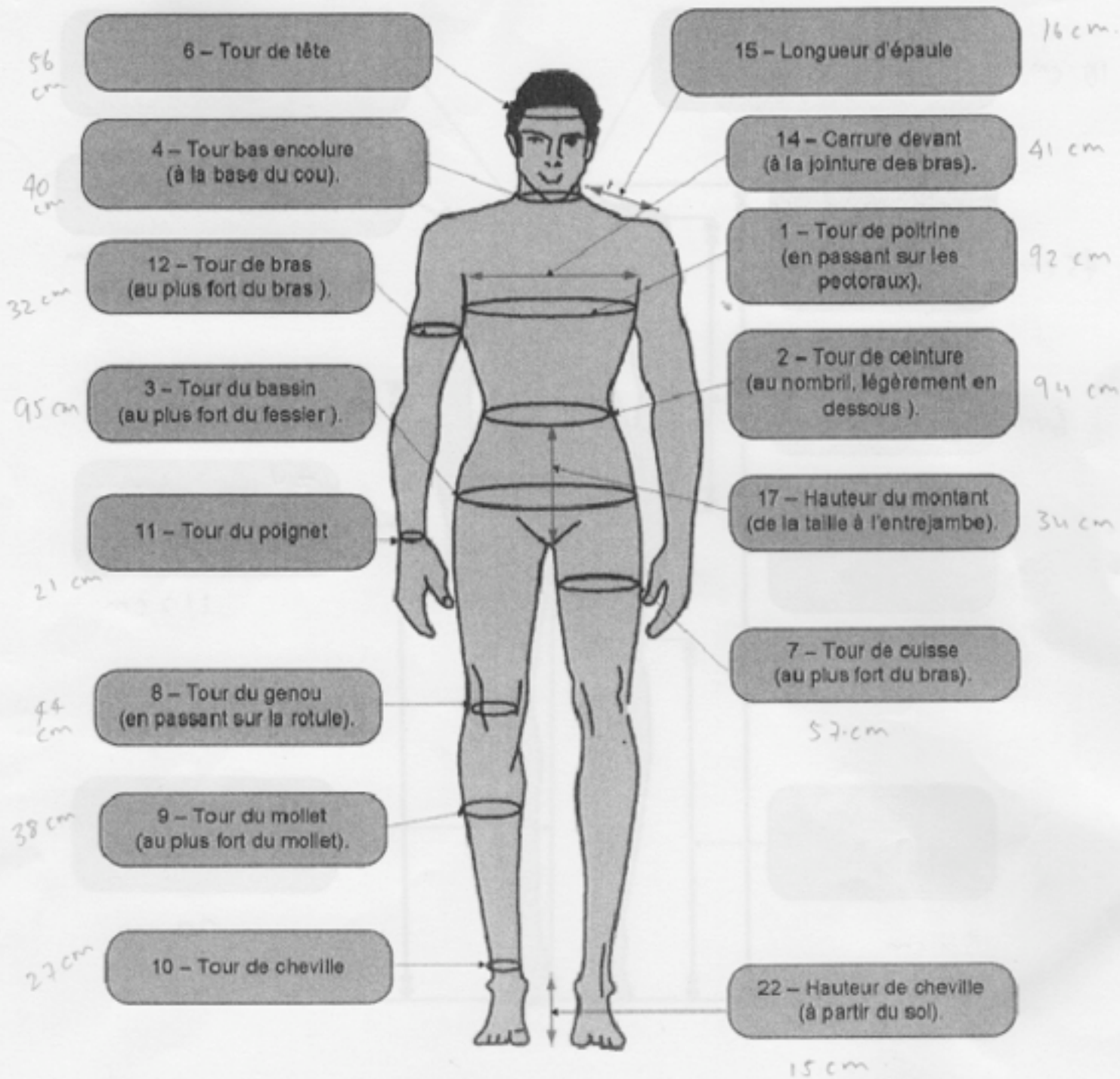
Chris
I. Iallbeeharry

All measured in cm.



all measured in cm.





5 - Longueur 7ème cervicale au point d'encolure

23
Carrure dos
(sur mesure uniquement : d'une épaule à l'autre)

16 - Longueur taille dos
(de la 7ème cervicale à la taille).

13 - Carrure dos
(à la jointure des bras).

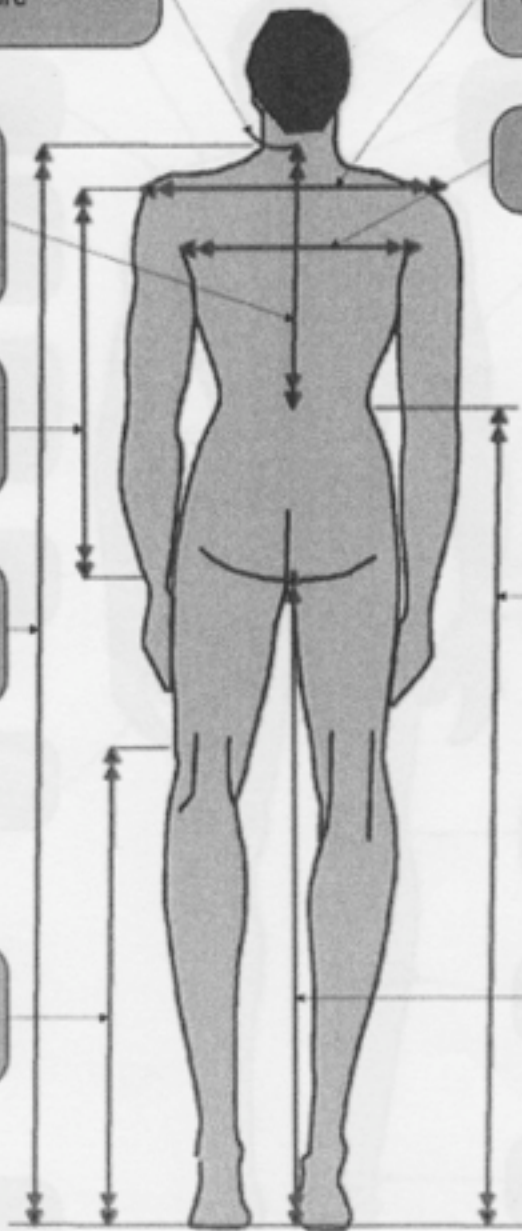
21 - Longueur du bras
(du bord de l'épaule au poignet).

20 - Hauteur du corps

24
Hauteur latérale à la terre
(de la taille au sol).

18 - Hauteur du genou
(du sol à la rotule).

19 - Longueur d'entrejambe
(du sol à l'enfourchure).



10 cm

45 cm

64 cm

1 m 50 cm

54 cm

40 cm

112 cm

79 cm

Men's shirt → $\frac{\text{Mur}}{490}$

Trousers → 590

Ladies Blouses → 475

Trousers → 575

waist Coat → 580

CELL ORGANELLES, STRUCTURES + FUNCTIONS

CELL MEMBRANE

location: on the outside of an animal cell and inside the cell wall of a plant cell

function: boundary that provides limited support to the cell and controls movement of materials in and out of the cell

CELL WALL

location: on the outside of a PLANT CELL

function: gives support and shape to cell

CHLOROPLASTS

location: distributed throughout the cytoplasm of a PLANT CELL

function: makes food by photosynthesis

CYTOPLASM

location: jellylike material throughout a cell

function: cellular liquid in which organelles are suspended

ENDOPLASMIC RETICULUM (ER)

location: distributed throughout the cytoplasm of a cell

function: makes lipids (fats) and packages proteins for delivery out of the cell

GOLGI COMPLEX (body/apparatus)

location: distributed throughout cytoplasm of a cell

function: changes, packages, and transports materials out of the cell

LYSOSOMES

location: distributed throughout cytoplasm of an ANIMAL CELL

function: digests food particles, waste, and foreign invaders (viruses, bacteria ...)

MITOCHONDRIA

location: distributed throughout cytoplasm of a cell

function: breaks down food molecules and releases energy

NUCLEUS

location: near the center of a cell

function: controls cell activities

RIBOSOMES

location: on ER and throughout the cytoplasm of a cell

function: make proteins

VACUOLE

location: distributed throughout the cytoplasm of a PLANT CELL

function: stores water and other substances



NEW STUDENT CONTRACT

ACCEPTANCE OF OFFER OF ADMISSION & COMMITMENT TO ENROLL

Must be completed and returned on or before registration

Student Agreement Conditions

Introduction

For students to get their best out of their time at Apollo Bramwell Nursing School (the "School"), we must both recognise that we owe obligations to each other. Our obligations require us to deliver and support your individual programme of study and to ensure that your experience with us will be positive and enriching. At the same time, we have to balance the interests and entitlements of many other students and the obligations we have with other parties and stakeholders to manage resources in a way which is efficient and effective. Your obligations include pursuing your studies diligently and abiding by the School's rules and regulations which form part and parcel of this agreement (the "Agreement"). The purpose of this document is to set out clearly and in detail what our respective obligations are. When you accept the offer of a place at Apollo Bramwell Nursing School, a legal contract will come into existence between you and the School. The terms and conditions of the contract are as set out below and your acceptance of a place is expressly subject to them.

The term 'campus' and 'premises' refer to the site where Apollo Bramwell Nursing School is situated. During your enrollment with the School, or any other time as shall be decided upon by the school, the location where the course is offered may change.

1. Status and Legal Effect of these Conditions

1.1 These conditions are the standard enrolment conditions for students of the School. Together with this Agreement, you will be required to abide by the rules and regulations in the Student Handbook. These conditions form the contract between the School and you, the student, with regard to your programme of study at the School ('the Programme'). If these conditions conflict with any other document(s) generated by or on behalf of the School, these conditions shall take precedence over the other document(s).

1.2 These conditions, and any other document to which they refer and the matters referred to, form the entire Agreement and understanding between you and the School with regard to the Programme and replace any other written or oral promises, undertakings or representations.

1.3 No contract will exist until you formally notify the School of your acceptance of an offer in writing and you sign the enrolment form for the programme.

1.4 It is a condition of entry on to the Programme that you must complete and sign an enrolment form when requested to do so by the School.

1.5 Breach of any of these conditions may give rise to disciplinary action being taken against you under the disciplinary procedures of the School and/or termination of this Agreement.

1.6 This Agreement between the School and you, the student, does not confer any rights or benefits on third parties (including your parents).

2. The School's Obligations

2.1 The School undertakes, subject to these conditions, to:-

2.1.1 Deliver the Programme;

2.1.2 Make available to you learning support facilities and other services as it considers appropriate. The School reserves its right to make variations from time to time to the services and facilities provided, for any reason at its sole discretion and without the student having any claim for termination of the Agreement and/or refund of fees save and except in accordance with clause 2.3.3 below.

2.2 The School will deliver the parts of the Programme which are within its control with reasonable care and skill.

2.3 The School will use reasonable endeavours to deliver the Programme in accordance with the description applied to it in the Student's handbook, for the academic year in which you begin the Programme. An 'Academic Year' shall mean the yearly period of the Programme, the dates of which shall be notified to you by the School. However, in view of efficient resource and logistical management, the School shall be entitled at any time in respect of the Programme (including work placement, if applicable):-

2.3.1 To alter the timetable, location and methods of delivery (including but not limited to transferring delivery of the Programme from one campus to another);

2.3.2 To make reasonable variations to the content of the syllabus and assessment;

2.3.3 To discontinue or decide not to provide Programme or to merge or to combine it with other Programmes of study in the future, if such actions is deemed to be necessary by the School at its sole discretion.

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B
UK

2.3.4 If the School discontinues or decides not to provide the Programme prior to its commencement then it will use reasonable endeavours to notify you in advance and you shall be entitled to withdraw your application by written notice to the School. The fees (as defined in Clause 4 below) paid by you will be refunded.

2.4 The School shall not be liable for any failure or delay in performing its obligations if the failure or delay is due to any cause beyond the School's reasonable control, which shall include, but not be limited to, any governmental action, strikes, civil and/or international commotion, fire, flood, war, labor disputes, weather conditions, natural disasters or act of God or *force majeure*.

3. Your Obligations as a Student

You agree as follows:-

3.1 To comply with your obligations under the conditions of this Agreement and the School's Rules and Regulations as reflected in the Student Handbook concurrently signed with the former;

3.2 That you have obtained the necessary information to make an informed choice about the Programme and that you will have undertaken any preliminary reading or other academic preparation as requested by the School by the start of the Programme;

3.3 To study diligently, and to attend promptly and participate appropriately at lectures, courses, classes, seminars, practical and laboratory sessions, tutorials, work placements and other activities which form part of the Programme as required (subject to absence authorised in accordance with procedures applicable to the Programme, in respect of which you agree to undertake all additional study and other activities which may be necessary to avoid disruption to your work);

3.4 To fulfill all the academic requirements, including submission of course work and other assignments, and attendance at examinations, of the Programme on time and in accordance with conditions imposed by the School;

3.5 To prepare adequately for any activity which you are required to undertake within or outside the School, at all times conducting yourself in an appropriate manner;

3.6 To pay all Fees and other moneys due, by the dates specified by the School, unless previously agreed otherwise by the appropriate School authorities;

3.7 To provide the School with a contact name and details which you are willing to permit the School to use at its sole discretion and without further reference to you in a situation which the School reasonably regards as an emergency;

 ³ 

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3.7 To provide the School with a contact name and details which you are willing to permit the School to use at its sole discretion and without further reference to you in a situation which the School reasonably regards as an emergency;

  3

3.8 To comply with any ethics, professional standards and requirements which are applicable in relation to the Programme;

3.9 At all times whilst you are a student of the School to co-operate with members of staff and to behave appropriately, responsibly and with respect for other students, staff and members of the public and to refrain from causing damage to any property;

3.10 To notify the School if any of the information which you have submitted to the School changes;

3.11 To act in accordance with any reasonable instructions or requirements issued to you from time to time by or on behalf of the School;

3.12 To abide by any special conditions relating to the Programme set out in the student handbook or similar document issued by the School in respect of the Programme, or as otherwise notified to you by the School;

3.13 That all ideas, materials or work produced by you and submitted as part of the requirements of the Programme and all intellectual property rights therein will be the absolute property of the School, unless the School and yourself have specifically agreed in writing to the contrary;

3.14 That all information you have given and will give the School is complete, true and accurate in all material respects.

4. Fees and Payments

4.1 It is your responsibility to ensure that the School's fees in respect of the Programme (including Registration Fees, Examination Fees, Tuition Fees or any other fees applicable), ('the Fees'), and all the other expenses relating to the Programme, are paid in each Academic Year of the Programme. Fees shall be remitted by you at the beginning during the academic year, in the manner to be stated on the Enrolment Form at registration or as otherwise agreed in writing, on a case by case basis, between yourself and the School.

4.2 The Fees do not include additional fees for reassessment/referral if the latter has taken place on more than two occasions as well as traveling expenses.

4.3 Condition 4.2 shall not apply if the School has agreed in writing that any alternative arrangement for the payment of the Fees will apply to you. Such alternative arrangements include payment of your own contribution by installments, in which case you will pay any surcharge imposed by the School if you pay any installment after the due date.



4.4 If you leave the School before the Programme has finished then you will not be entitled to a refund of all or part of your assessed contribution to the Fees paid by you.

4.5 For the purposes of condition 4.4 only, you will be considered to have left the School (whether or not you intend to commence a new course or Programme at the School in the following Academic Year) if all of the following steps have been taken:

4.5.1 The School has received written notification that you wish to discontinue the Programme or the School has notified you in writing requiring you to leave the Programme;

4.5.2 You have ceased to attend the lectures or other teaching activity; and

4.5.3 You have returned all items and materials owned by the School and have paid any outstanding sums owed to the School.

5. Failure to Pay the Fees and other amounts

5.1 If the Fees and any other amounts due to the School remain unpaid 28 days after the date they are due, the School shall be entitled to take legal action to recover the debt and/or take any or all of the following steps:-

5.1.1 Exclude you from the School and end this Agreement, in which case the provisions of **condition 10** will take effect;

5.1.2 Withhold from you any award or qualification which would otherwise have been made to you, suspend further performance of its obligations under this Agreement and/or refuse to allow you to proceed to any further stage of the Programme, until all outstanding amounts have been paid, or arrangements for payment have been established which the School considers satisfactory.

6. School Rules, Regulations and Requirements

6.1 You must comply with all policies, codes, rules, regulations and requirements of the School in existence during the Programme which relate to the activities of students at the School, or which may apply to the Programme. These are collectively referred to in the Student Handbook, and should be abided together with this Agreement, and include , but are not limited to the following:-

6.1.2 The School's regulations on acceptable use of computers and information technology;

6.1.3 All relevant health and safety regulations and School regulations;

6.1.4 The School's Data Protection guidelines;



6.1.5 All policies, codes, rules, regulations and requirements of any other relevant organization or institution, if required as part of the Programme, as such policies, codes, rules, regulations and requirements as amended from time to time.

6.2 If your studies with the School are terminated as a result of disciplinary action taken against you in accordance with the disciplinary procedures of the School, this Agreement shall end automatically without the need for any notice, unless the School agrees otherwise in writing.

6.3 If you are expelled or dismissed from any institution or organization other than the School which you are required to attend or be a member of as part of the Programme, the School shall be entitled to end this Agreement immediately by written notice to you.

7. Confidentiality Code of Conduct for Clinical Placement

7.1 During the course, you will be required to undertake clinical placement ('placement') in either public hospitals or at Apollo Bramwell Hospital. You will be dealing with patients, nurses and doctors and as such, you shall be bound by a legal duty of confidence to protect personal information you may come into contact with during the course of your placement.

7.2 This means that you shall keep Personal Identifiable Information strictly confidential e.g. patient and staff records. It should be noted that you may also come into contact with non-personal identifiable information which should also be treated with the same degree of care.

7.3 Definition of Confidential Information

7.3.1 Confidential information can be anything that relates to patients (including Personal Identifiable Information), staff (including non-contract volunteers, bank and agency staff, locums and students placements), their families or friends however stored. For example, information may be held on paper, floppy disc, CD, memory sticks, computer files, print out, video, photograph, or even heard by word of mouth. It includes information stored in portable devices such as laptops, digital portable devices, such as palms/blackberries/Treo etc, mobile phones and digital cameras.

7.3.2 It can take many forms including medical notes, audits, single assessment documents, employee records, occupational health records, etc. This list is not exhaustive.

7.3.3 Person-identifiable information is anything that contains the means to identify a person, e.g. name, address, date of birth, National Identity Card, etc. Please note that a visual image such as a photograph without any other personal information such as name or address can be sufficient to identify an individual.



7.4 Principles of Confidentiality

7.4.1 Common Law Duty of Confidentiality – A duty of confidence arises when one person discloses Confidential Information to another (e.g. patient to clinician) in circumstances where it is reasonable to expect that the information will be held in confidence. This covers not only what a patient may reveal, but also what the professional may independently conclude or form an opinion about based on examinations or assessments as well as communications.

7.4.2 When you are responsible for Confidential Information you must make sure that the information is effectively protected against improper disclosure when it is disposed of, stored, transmitted, or received;

7.4.3 When patients give consent to disclosure of Confidential Information about them, you must make sure they understand what will be disclosed, the reasons for disclosure and the likely consequences;

7.4.4 You must make sure that patients are informed whenever Confidential Information about them is likely to be disclosed to others involved in their health care, and that they have the opportunity to withhold permission. Patients should be made aware of their right to change their mind at any time up to the point of disclosure;

7.4.5 You must respect requests by patients that Confidential Information should not be disclosed to third parties, save in exceptional circumstances (e.g. where the health or safety of others would otherwise be at serious risk). Patients should be advised in a non-confrontational way of any consequences of refusal to allow the disclosure of information from their records;

7.4.6 A record should be made of any decision not to disclose Confidential Information including the date and background to any discussion or correspondence with the patient. If necessary, further advice should be sought from your mentor;

7.4.7 If you disclose Confidential Information you should release only as much information as is necessary for the purpose – if it is appropriate to share information gained in the course of your placement with other health or social work practitioners, you must make sure that as far as is reasonable, the information will be kept in strict professional confidence and used only for the purpose which the information was given;

7.4.8 If you decide to disclose Confidential Information, you must be prepared to explain and justify your decision. If you are unsure whether or not to disclose information or whether you need to ask for patient consent, please ask the advice of your mentor.



7.4.9 You must always abide by these principles.

7.5 Failure to comply with Condition 7.4 of this Agreement will be viewed as a breach of confidentiality and may result in disciplinary and/or legal action and against you by the School and possibly risk legal action by others.

8. Change of Circumstances

In addition to the School's right to end this Agreement in conditions 6.2 and 6.3, the School shall be entitled to end this Agreement immediately by notice in writing to you in the following circumstances:-

8.1 If after the acceptance of an offer by you there is a change in your circumstances or if the School becomes aware of information relating to you not previously known to it (including, but not limited to, information about criminal convictions or activity) which in the reasonable opinion of the School makes it inappropriate for you to study on the Programme; or

8.2 If, in the reasonable opinion of the School, you have failed to provide the School with all relevant information or have supplied false or misleading information.

9. Exclusion of the School's Liability

9.1 The School does not accept responsibility, and expressly excludes liability, for the following, in respect of which you are advised to arrange appropriate insurance cover:-

9.1.1 Any loss or damage to your property (including but not limited to any motor vehicle or cycle) while that property is on the premises of the School, unless caused by the negligence of the School or its employees;

9.1.2 In case of your negligence and misconduct causing injury or loss of life of patients under your supervision during any clinical training;

9.1.3 Death or any personal injury suffered by you unless caused by the negligence of the School or its employees;

9.1.4 Loss of profit, loss of earnings, loss of opportunity, disappointment, distress or injury to feelings, living expenses and any indirect or consequential loss or damage, however arising, suffered by you as a result of any breach by the School of these conditions or any other act or omission of the School or its employees or agents.

9.2 Although the School shall endeavour to ensure that computer equipment and software available for your use has reasonable security and anti virus facilities and protections, you do use such computer equipment and any software provided by the School at your own risk. The School shall not therefore be liable (subject to condition 9.4) for any loss or damage suffered by you as a result of use of any computer equipment or software provided or made available by the School to you, including (but without limiting the general nature of this condition) any contamination of software or loss of files as a result of using the School equipment or software.

33

B

8
UR

9.3 If the School is found liable to you for any breach of these conditions or for any other act or omission of the School or its employees or agents the liability of the School shall be limited to the Fees actually paid by you, except in relation to liability referred to in condition 9.4 below.

9.4 Nothing in this condition 9 or in the rest of these conditions shall operate to exclude the School's liability for death or personal injury caused by the School's negligence, or for fraudulent misrepresentations.

10. Requirements on termination of this Agreement

If at any time the School terminates this Agreement as a result of its rights under the terms and conditions of this Agreement or generally or if this Agreement terminates automatically:-

10.1 The School shall be entitled to refuse to enroll you on the Programme, if at the date of termination you have not already enrolled;

10.2 The School shall be entitled to require you to stop studying on the Programme, and to leave the School immediately, if at the date of termination you have already enrolled;

10.3 The School shall be entitled to refuse your enrolment on or application for another course.

10.4 Any action taken by the School under conditions 10.1 or 10.2 shall not restrict the ability of the School to take any action against you to which it may be entitled;

10.5 The School shall not be liable for any loss or damage of whatever nature which you may suffer as result of any action taken against you by the School to terminate this Agreement or disciplinary action by the School (provided the action by the School is taken properly in accordance with these conditions or the School's procedures); and

10.6 You shall be required to return forthwith the **Student Identification Card** issued to you upon enrolment.

11. Parking

11.1 You should comply with applicable rules of the premises.

11.2 You agree to comply with any action required by the School in respect of the above and if you fail to do so, the School may take such enforcement action as is appropriate, including but not limited to disciplinary action, imposition of fines and removal or immobilization of any vehicle parked without appropriate permission and/or in breach of the School's requirements.

  9

12. General

12.1 If any provision of these terms and conditions is, or becomes, illegal, invalid, void or unenforceable, that shall not affect the legality, validity or enforceability of the other provisions.

12.2 Any notice or other communication made under this Agreement shall be in writing and addressed to you at the last address notified by you to the School, and shall be sent to you through registered post to that address.

12.3 If you breach this Agreement and the School chooses not to exercise any right which it may have against you, that shall not prevent the School from taking action against you in the future in respect of that breach or any further breaches by you.

12.4 This Agreement shall be governed by and construed in all respects in accordance with the laws of Mauritius and the parties to this Agreement agree to submit to the jurisdiction of the courts of Mauritius.

12.5 Nothing contained in or relating to this Agreement shall constitute or shall be deemed to constitute a partnership or agency relationship between the Parties and no party shall have any authority to act for or to assume any obligation or responsibility on behalf of any other party.

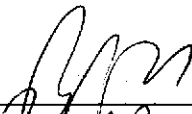
12.6 None of the Parties may assign its rights or obligations under this Agreement in whole or in part, without the prior written approval of the other Party and any such attempted assignment shall be deemed null and void.

12.7 No amendment of or addition to this Agreement shall be effective unless in writing executed by each of the parties

This Agreement is drawn up in two (2) originals and signed in good faith on this 4th day of APRIL 2014 with each Party acknowledging receipt of one signed original copy.

Signature: 

The Apollo Bramwell Nursing School as duly represented by:

Signature: 
Student Name: A B S T

Learning Styles Questionnaire

by Honey & Mumford

This questionnaire is designed to find out your preferred learning style. Over the years you have probably developed learning habits which help you benefit more from some experiences than others. Since you are probably unaware of this, this questionnaire will help you pinpoint your learning preferences, so that you are in a better position to select learning experiences to suit your style.

There is no time limit to this questionnaire. It will probably take 10-15 minutes. The accuracy of the results depend on how honest you can be. There are no right or wrong answers. If you agree more than you disagree with a statement, put a tick by it. If you disagree more than you agree put a cross. Be sure to mark each item either with a tick or a cross.

- ☐ 1 I like to be absolutely correct about things.
- ☐ 2 I quite like to take risks.
- ☐ 3 I prefer to solve problems using a step by step approach rather than guessing.
- ☐ 4 I prefer simple, straightforward things rather than something complicated.
- ☐ 5 I often do things just because I feel like it rather than thinking about it first.
- ☐ 6 I don't often take things for granted. I like to check things out for myself.
- ☐ 7 What matters most about what you learn is whether it works in practice.
- ☐ 8 I actively seek out new things to do.
- ☐ 9 When I hear about a new idea I immediately start working out how I can try it out.
- ☐ 10 I am quite keen on sticking to fixed routines, keeping to timetables, etc.
- ☐ 11 I take great care in working things out. I don't like jumping to conclusions.
- ☐ 12 I like to make decisions very carefully and preferably after weighing up all the other possibilities first.
- ☐ 13 I don't like 'loose ends', I prefer to see things fit into some sort of pattern.
- ☐ 14 In discussions I like to get straight to the point.
- ☐ 15 I like the challenge of trying something new and different.
- ☐ 16 I prefer to think things through before coming to a conclusion.
- ☐ 17 I find it difficult to come up with wild ideas off the top of my head.
- ☐ 18 I prefer to have as many bits of information about a subject as possible, the more I have to sift through the better.
- ☐ 19 I prefer to jump in and do things as they come along rather than plan things out in advance.
- ☐ 20 I tend to judge other people's ideas on how they work in practice.

- ☐ 21 I don't think that you can make a decision just because something feels right. You have to think about all the facts.
- ☐ 22 I am rather fussy about how I do things - a bit of a perfectionist.
- ☐ 23 In discussions I usually pitch in with lots of ideas.
- ☐ 24 In discussions I put forward ideas that I know will work.
- ☐ 25 I prefer to look at problems from as many different angles as I can before starting on them.
- ☐ 26 Usually I talk more than I listen.
- ☐ 27 Quite often I can work out more practical ways of doing things.
- ☐ 28 I believe that careful logical thinking is the key to getting things done.
- ☐ 29 If I have to write a formal letter I prefer to try out several rough workings before writing out the final version.
- ☐ 30 I like to consider all the alternatives before making my mind up.
- ☐ 31 I don't like wild ideas. They are not very practical.
- ☐ 32 It is best to look before you leap.
- ☐ 33 I usually do more listening than talking.
- ☐ 34 It doesn't matter how you do something, as long as it works.
- ☐ 35 I can't be bothered with rules and plans, they take all the fun out of things.
- ☐ 36 I'm usually the 'life and soul' of the party.
- ☐ 37 I do whatever I need to do, to get the job done.
- ☐ 38 I like to find out how things work.
- ☐ 39 I like meetings or discussion to follow a proper pattern and to keep to a timetable.
- ☐ 40 I don't mind in the least if things get a bit out of hand.

Scoring

For each question you ticked on the other sheets, put a '1' beside the question number on this sheet. Put nothing for crosses. Add up the 1s in each column.

1	4	2	11
3	7	5	12
6	9	8	16
10	14	15	18
13	20	19	21
17	24	23	25
22	27	26	29
28	31	35	30
38	34	36	32
39	37	40	33

Theorist

Pragmatist

Activist

Reflector

Nursing is
the gentle art of
caring.



Active Listener → when the pt start talking, you should stop talking & listen.

Advisor → Listen to the problem & solve, then advice.

Negotiator → negotiate between party.
(e.g. if the pt doesn't want to undergo a surgery you talk to the relative)

Roles of Nurses

Differentiate between a doctor & a nurse.

Doctor → cure with medical prescriptions.

Nurse → care about the patient.

DEFINITIONS OF NURSING.

SYSTEMS
ETHICS

HENDERSON

MODEL

Nightingale

ANA.

The varied activities that constitute the duties of a nurse. The profession of a nurse. A nurse starts a shift with a handover, to attend to nursing duties, to meet patients' basic needs due to sickness, surgical intervention. The nurse prepare (pre duties - duties - post duties) for a shift. The nurse is ready to respond to the prescribed requirements of the patient.

Matrix, mosaic-

Direct, goal oriented adaptable to the needs of the patient.

Individual - how to techniques to collect data on a notes. NOT

too many-

Nursing as a caring relationship that helps the client to achieve. Recipients of nursing are sometimes

A patient is a person

Nursing is both an art and a science that leads to therapeutic outcomes in client.

Nursing creates therapeutic change through the application of therapeutic principles - Rook in caring. Roper model -
It describes actions that are beneficial to the patient.

Chart - structured bar

Humour Non judgemental - approach - Empathy.

Therapy - listen twice -

Active listen -

1st Principle 1: Listen story talking

2nd

2:

Comparison of Social and Therapeutic Relationship

Social

Spontaneous rhythm

is planned and

goal directed -

Differences between Social and Therapeutic Relationship

Caring -

Curing versus caring -

Curing makes chart of disease or disability -

Caring nurtures the person even if the disorder is incurable.

NURS1001

Thurs - 15-04-14.

Day 4/5

ROLES OF NURSES.

4

^{Teacher}
THE MAIN ROLE OF A NURSE IS AN ADVOCATOR

5/5/15

Motivator AD

Comfort
zone -

Preceptor

insulin

Mentor

Coregiver

Educator Bandage

Counselor

1137 Communicator

ROLE OF NURSE

manager - SNM
a group

Role
model

Coach
show

leader

Advisor

Researcher

Advocate

THE main Role of the is / an / ADVOCATOR

ADVOCAT

a ~~dump~~ a ventilator - protector - champion -
You cannot be a leader if you do not have
followers:

advocate:- a patient has pain cannot talk - nurse says to

others it has pain
When can take nurse to

Talk nursing do not cross over

NURS1001

TUES-15-04-14
MORNING.
WATE.

DRAGON

CYA
COVER
YOUR
ASS
DO NO
HARM

NURSE
Reker

NURSE
PRATTINGR.

Chaired

NURSE
ADMINISTRATOR

EXTENDED.
or
Expanded

NURSE
Spender

NURSE

NURSE
MURKIN

NURSE
Indirk

Nursing -

CARING -

Ketones

Time
Jokes

0846 Power of Observation - All Senses - used - if you
want to be good clinician - The else he indirectly ^{HARVARD} Refers -
he said

"People don't care how you know till they know
how much you care"

Caring behaviors - demonstrated in Nursing Practice.

Demonstration of Concern

Anticipation of client needs, providing, delicate
communication - heard -

0856 Co Transcultural nursing - Lerninger

NBTDC

Introducing self to client

call patients by their preferred name . Mr. Mrs Doctor.

Spent time into the patient to learn he plan I can

BE GENEROUS WITH YOUR INFORMATION + INTER
ACTION -

SCOPE OF NURSING - TYPES of Charts.

Individual - Families - Communities

NURS1001

Thurs - 15-04-14 -

MyGua
chart 1/12

AIMS of NURSING

Four broad aims of nursing practice identified -
PROMOTE; PREVENT - RESOLVE - Facilitate.
health illness Health coping
wellness dying -

LAST
Office

FOUR AREAS INVOLVED.

Reduce weight - Stop cigarettes.

Health promotion is increasing people's well being
increasing and health potential.

RESTORING HEALTH is focussing on individual

with illnesses and range from early detection to
rehabilitation and healthy living, recovery -

muscle

740 mmHg is hypertensive / hypotensive systolic 90

Systolic < 90

CARE OF DYING focuses on -

NURSES ROLES

09/5

Nurs 1001

16 - APRIL 2014.

DOUGUN

Names
Dates

History of Nursing
44 - 1965 - 42 per UK
Nn, Nursing Council -

PREPARE
BEFORE
PRE-OP-
POST-

Diagnosed nursing care problem.

ADVOCATION
EFFECTIVENESS

Prescribe - nursing care

Nursing diagnosis is fashionable.

Research,
Nurse

What are the characteristics of a good nurse? Leadership skills, Inspire people, passion get involved.
500 words.

Florence Nightingale.

Was born in 1820 and died in 1910. She was born in Italy. She went to Germany to study.

Crimean War:

The Secretary of War asked her to take charge of the hospital in Scutari in Turkey.

Nightingale showed up with 38 trained nurses at a place where a death rate of 40% - Lack of hygiene -

Nurs1001

History of Nursing
F. Nightingale

Day 1001
16-04-14

Infection control the most important
problem of

L. Garbutt

P. Health

D.O.N.

The greatest invention is laundries -

She laundried etc.

She established cleanliness and sanitation rules.

Patients received special diets and plates of food

She improved water supply.

0900

Patients received proper nursing care.

Nightingale established a story of great
repute.

RAFT

The story of a raft - De teacher -

Nightingale's '7' Basic tenets were:

1 Content of edu defined by nurses.

2. Nurse educators are responsible for to

3. Care provided by students and graduates of the
nursing program

3 Educators should be trained nurses
themselves -

4 Nurses should be prepared with advanced

Nurs/001

HON

Doc, Linc

Image of Nursing

0928

Work with them at their weekend and most-
Happy nurse.com

NURS001 -

Monday 21st April, 2014

Don
Gohet.

NURS106.

Integrating - active policies - Respectively privacy -
trust, respect, provide feedback =

trust of stakeholders, community, family, trust, college.

objective of organisational achievement - organisation of products,

good governance - Finance - Legality to extend
institution -

Compassion - consider, empathy, kindness and trust.

advocacy for it, others before ours - trust & respect

listening and understanding - and connected Emotionally
with other

Units - one key together here = the family -
School head, clubs, applications groups -

What's unit

Unit as a family - harmony among teams.

Collaboration, contribute to success of, share

your experience, add and be branch to the family
Happy together as well as we are children

Nursing

Monday 14-April, 2014

Doq
GURSH.

The word nurse originated in Latin word NUTRIX
meaning "to nourish"

Take care of the sick, injured, and aged people.

To understand what nursing is, one must first define
the word. Many definitions exist, some of which
misrepresent the complex knowledge and skill of
professional nursing.

Communication skill must be your FORTE.

Nightingale 1860 100 years ago. The lady with the lamp.

Virginia Henderson.

The unique function of the nurse is to assist the
individual, sick or well, in the performance of those activities
contributing to health and well-being

that he would perform unaided if he had the
necessary strength, will, knowledge, and resources
to help him gain independence as 1966
YOU SHOULD DO NO HARM TO PATIENT

NURS1001

Monday 14-Apr-2014

Don
Went.

The gift of time -

The nurse's mark on a person -

Challenge yourself -

Diversity - Respect - Be a student -

THE FUNDAMENTAL VALUES OF NURSING -

Nursing is -

Caring

Art

Science

Character

Integrity

Empathy

Health promotion
maintenance

Restoration of life

Wellness promotion

Nursing is a science; research.

Nursing is evidence based EBN

Nursing is concerned with health promotion,
health maintenance, and health restoration.

Nursing theory model -

You cannot care to learn to care
from a book -

Customer care kindness.

Nurses are the heart of healthcare.

Nurses dispense, we fight, we care as

long as we have a prescription.

when you are a nurse
you know that was lies.

You will have a life or a life will

have you

— Do not influence other students in your class.

Nurses.com

Scrubsmag.com

Both a nurse & changes everything

Apt care, observe, Rept - Re nursing problem -

1. Invest in yourself -

2. Nursing profession -
The most honest. 13 years in a row.

$\frac{1}{111}$

$\frac{1}{111}$ all times.
can.

3. Variable person

4. Nursing / makes a difference

1. Skill, art & humanities

2. Care & compassion

3. A career -

4 - Love work force -

5 - Holistic care -

6 - Challenges & obstacles

7 - Who & what to H. care environment

8 - Build, wisely, career own with a
skills

NURS1001

MONDAY 18th APRIL 2014

Shirley

Nurs -

1. A discipline -

2. An order -

3. A chain of command -

4. Uniformed role -

5. Whether he does, under - obs.

nursing -

helps - a weakness.

make up for a deficiency.

a weakness



Nursing is

is the gentle art of caring.

Def: NURSING IS THE GENTLE ART OF CARING

make a difference every day -

CHANGE -

But we are not to be lead
It is a way of life
and allows you to turn -
you can change -

Nurs 101

Monday 18th April 2014

Day

Nursing

Introduction
Purpose of Nursing

Value of nursing

? What is nursing

Role of nursing

History of nursing

History of nursing

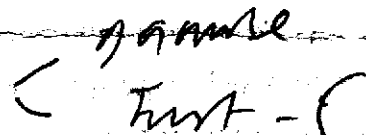
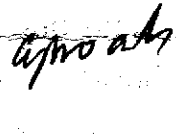
Contemporary image of professional nursing

When you imagine a nurse, what

Code
Red
Blue/ Purple

Code blue

- Cardiac
arrest

Mental picture -  First -  approach

VALUES

SKILL

i. Someone you can ask for help?

ii Trust

v. Consistent

iii competent

vi control

iv confident

vii committed

Size C^s
of
nursing

I. In order -

2.

NURSING

Mon, 18th April 2014

My
Growth

NURSING

Quality - Standard, measurable components - we
lead them, consensus is reached - Objectivity
to measures, set goal + standard - values.
Agreed metrics, structure processes - outcomes -
compare standard - 1st - 1st - 2nd - we
to meet or exceed. The extent to which the
values - is derived, must be expectation of diet in
a sustainable manner.

Respect - is very important in daily - to respect
parent, child etc, respect school rules, to
respect for the cultural traditions, other people
feelings and rights, other opinions, taken for
granted - is it a behavior, and attitudes, values.
be relevant, non-harmful, to rights, to civil disci-
pline - common, privacy, dignity of patient - build
relationship, commitment, at one for the patient
self-respect - respect others - improve well-being.
human. BB ABH core value CRH-10

Nursing 1

Monday 14-Apr-2024

Ben
Gym -

Research & Practice - Nym - J. S. -

~~Nym~~ Nym is undefined -

Nym is Caroleen -

Nym is uncalculated -

Nym is in Slicker -

Nym is in tech school -

Nym is 'at an art - gallery -

Nym is humanistic. Humanistic. Humanistic -

Nym is environmentalist -

WARNING

↑

- Challenges ahead -

- in Disrupt -

- in Nym is not -

- Attitude changes everything -

- my patient is my business -

H.

Assess

The main role of a nurse is to assess

NURS1001

MONDAY THE 8th APRIL, 2014.

BOY
GURUSH

NURSING

MON - THUR - WED 12-15 hrs

What is nursing?

Registered nurse -

Selling nursing as a profession - A wonderful Journey -

Art and Science - To go on the work to

practice - an orientation - anecdotal -

Why you want to join nursing? Talking about

the values of and importance of nursing. People of

different. Practising core values of the school -

Values - Compassion, commitment, integrity,
Quality, Respect, Unity. Core values of

The same set of Values -

Com - Responsibility - As advertised on YouTube -

Comp - Consistency - dedication - emotional

bonding - delegated - giving the extra miles, support -

passionate work - keeping a promise, a cornerstone -

Int - uncompromising - high level of awareness -

Locality - beyond locality, well understood -

0800

* Cancellling Monthly -

Q&A

2204

2014.

Why theories?

Why T:
Analysis

30NT

Proper, logen & theory model.

0825

ADL

Therapy

5

How to identify theory & how

practice

Skill

EvidenceM20-
2014

< Explanation > Research - EBP

EBW ^{Craving} ^{is} ^{worthwhile} it

- 1: Information - Choice - holders
- 2: Research dept
- 3: Education

Every one is worthing it.

Form practice on several researches -
Implementation - trends.

Theory - research - EBP - Path.

① Theory ② Concept ③ Proposition ④ Conceptual Definition
 7. frame work ⑤ Paradigm ⑥ metaparadigm ⑦ Practice

discipline - Freud - Psychoanalytic d

Some of sexual pleasure is to work -

Semester 1

①

YEAR 1

2504
2014
0857
0910

late 1800s, 1800 < 1815; stand and say with
Don't know - axial & appendicular skeleton -
membrane, joints - Planes - Transverse > for elbow &
knee -

CELLS

Physiology

Who discovered cells? ROBERT HOOKE - used the
monastery kitchen to describe using the words cells -
Cancer? ONCOLOGY? ONCOLOGIST? Metastasis
goes somewhere else.

How normal cell divide? L

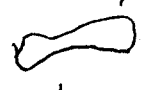
mitosis

Erythrocytes - 120 days life -

New person every 7 years -

McGraw Hill - Anatomy & Physiology - Philip Tate - Chapter 3 Seeley's

2 ft
length

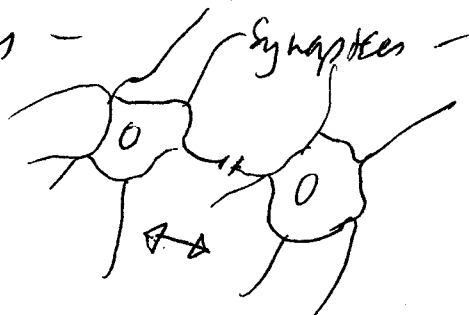
Neurone - #  ① Bicarbonate & greater.
surface area - for transport - capillary - due
red blood cell passes through a capillary -

2
size of
0926

Neurons have dendrites -

Common structures

- 1: nucleus
- 2: cell membranes
- 3: cytoplasm



A: intracellular
B: extracellular
C: interstitial
D: intravascular
E: thymus space
Compartment

CHOTANB

NURS1007

What is globalisation?

5

A Little History

In March 1952, Harry Markowitz, a 25 year old graduate student from the University of Chicago, published Portfolio Selection in the Journal of Finance. The paper opens with: The process of selecting a portfolio may be divided into two stages. The first stage starts with observation and experience and ends with beliefs about the future performances of available securities. The second stage starts with the relevant beliefs about future performances and ends with the choice of portfolio. Thirty eight years later, this paper would earn him a Nobel Prize in Economic Sciences.

Two basic elements of investments:

the investment opportunity;

the investor.

Our task for this class:

a model for financial assets;

a model for investors;

optimal portfolio selection.

One measure of the attractiveness of a portfolio is its Sharpe Ratio (S)22/04
20/14MAJOR SCHOOL OF THOUGHTS -

Psychology

1334

The structural relationship formed by the id,

3 ego and superego is the accumulation of societal norms

and personal values as interpreted by individuals.

The superego emphasizes not reality, but the ideal, and

1435 its goal is perfection, as opposed

S Freud (1931)

The Freudian Theory -

3

THE PRECONSCIOUS, THE CONSCIOUS, THE UNCONSCIOUS

IONS

1354

It has been suggested that stages - most important

is the phallic stage - experiencing the Oedipus or

2

Electra complex.

1433

Semester 1

YEAR 1

1313

2024

2014

Biological - 1

Psychodynamic - 2

Behavioural - 3

Cognitive - 4

Humanistic - 5

Our behaviour is explained by the different things. Alzheimer's person has changes in the cells of the nervous system. Genetic differences predisposes to some diseases. Learning disabilities persons - Biological.

3 Psychodynamics of Freud's model. The elements of the Id, ego, and superego. The Id is the biological and psychological drives that a person is born with that constitute the Id.

The ego is the component of the personality that mediates the drives of the Id with reality, in a way that promotes well-being and survival. This

The Superego it is often referred to as the conscience of the person,

What is metanursing {METANURSING}?

NURS

SCHOOL OF PSYCHOLOGY

CYOTANB

2404
2014

1. Behavioural
2. Cognitive

COGNITIVE: E. PIAGET ———> cognitive
Ulric Neisser

mental states, processes, problem solving.
memory - may be without scientific
basis.

Research ———> Quantitative ———> Testing social
Qualitative ———> social subject

memory - is a process - encoding, storing and

retrieving information -
recall

memory ———> storing
retrieval ———> codes

Nurs 100

UPTANB

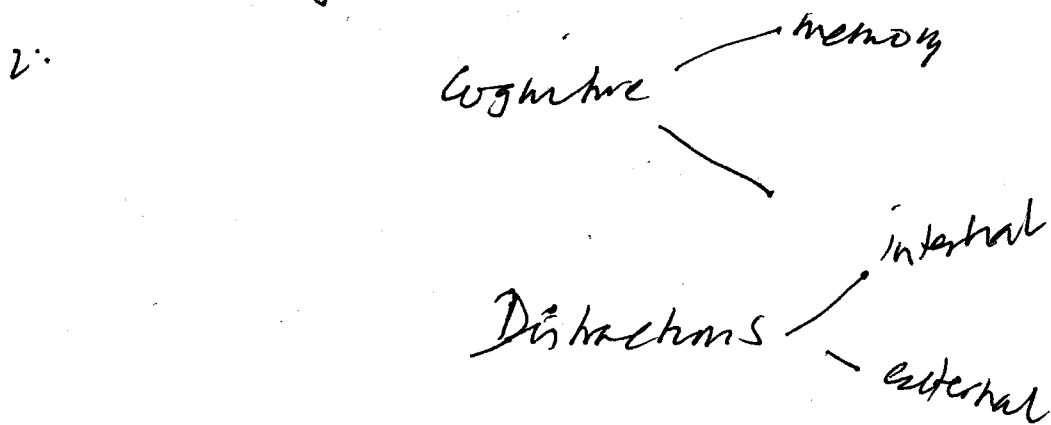
2404 models of memory - Atkinson

2014
Dispersed Health Education

1411

Janse 2000 distractions

1: acknowledge by looking at your patient -



Assessment

* Effective written and verbal information

Research has supported the benefits of many methods in adding
to written and verbal information - enhancing, hints

2005 Rana and Upton 2009.

1418

Semester 1.

1418

NURS/100

Piaget

Piaget's Stages of cognitive development. Piaget portrayed development as a staircase in which the different steps, or stages, are distinguished by specific kinds of thinking.

Formal operations 12 - 18 yr

Concrete operations 7-12

preoperational 2-6 -

Sensor motor 0-2

The adolescent can reason abstractly and think in hypothetical terms -

The child is egocentric!

1-18 years

Child - WHO

NURS1

FORMATS DATA

CHOTAB

2044.
408

↓
for attractive presentation
#

Delivering data in different format -

Highlighting -

Chunking Technique -

Primary effect - Recency effect - Chunking.

Reverse - first last thing.

Breaking the information into chunks to facilitate
data assimilation - Audio - Video -

Videotapes

Complex medical jargon #1

(Arthur 2006

Gibson et al 2002 -

It is too complex, they cannot read it
Attributing meaning to information -

1433

Value - dictions - a message of farewell.

Semester 4.

YEAR 1

Nurs / 60

DIAGNOSTIC Developmental Stage

DIAGNOSIS

2

18m - 3yrs Early childhood -

2014

2404

Basic Strength - Self control - Theme

3. Play Age 3 to 5

Ego development outcome - Identity V/
built

Basic Strength Purpose

4. School Age 6-12 years

Ego Development outcome: Industry V/Inferiority -

Basic Strength: Method and Competence -

1520

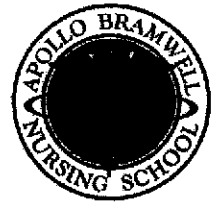
5 Adolescents 12-18

Ego development outcome - Identity V/Confusion -

Basic Strength: Devotion & Fidelity

6 Young adulthood 18 to 35

Basic Strength - Affiliation & Love



APOLLO BRAMWELL NURSING SCHOOL
NURS 1007 – IT & COMMUNICATION SKILLS

SYLLABUS

(1.5 Credits)

MODULE CONTENT

Unit 1

Writing of report using appropriate English Language grammar/vocabulary.

Unit 11

Grammar

- The sentence
- Different parts of speech in brief

Unit 111

Composition

- Analysis, transformation and synthesis of sentences
- Correct usage of sentences
- Reading Comprehension – Exercise of prescribed short answers.

Unit 1V

Written Composition

- Paragraph writing
- Story writing
- Comprehension
- Precise writing
- Essay writing

The Developmental Stages of Eric Erikson

Another theorist associated with psychoanalysis is **Erik Erikson**. Erikson's psychosocial **Stage theory of personality** remains influential today in our understanding of human development. Erikson felt the course of development is determined by the interaction of the body (genetic biological programming), mind (psychological), and Cultural (ethos) influences.

Erikson's basic philosophy might be said to rest on two major themes

Erikson's basic philosophy might be said to rest on two major themes : (1) the world gets bigger as we go along and (2) failure is cumulative.

Childhood and Society (Erikson, 1950), he provided a framework for the whole lifespan in terms of a series of tasks to be fulfilled.

1. Infancy : Birth to 18 Months old.

Basic strength : Drive and Hope.

He referred to infancy as the Oral Sensory Stage (a baby putting everything in his mouth).

2. Early Childhood : 18 months to 3 years.

Ego Development outcome : Autonomy v/s Shame.

Basic strengths : Self-control, Courage, and will.

Opportunity to build self-esteem and autonomy as we gain more control over our bodies and acquire new skills, learning right from wrong. Toilet training. Word ‘ No’.

If we are shamed in the process of toilet training or in learning other important skills, we may feel great shame and doubt of our capabilities and suffer low self-esteem as a result.

3. Play Age ; 3 to 5 years.

Ego Development Outcome : Initiative v/s Guilt

Basic Strength : Purpose.

During this period we experience a desire to copy the adults around us and take

Initiative in creating play situations.

‘ WHY ?’

4. School Age : 6 – 12 years.

Ego Development Outcome : Industry v/s Inferiority

Basic strengths: Method and Competence.

Latency stage – we are capable of learning, creating and accomplishing numerous new skills and knowledge, thus developing a sense of industry.

Social stage of development and if we experienced unresolved feelings of inadequacy and inferiority among our peers, we can have serious problems in terms of competence and self-esteem.

5 Adolescence : 12 to 18 years.

Ego Development Outcome : Identity v/s Confusion.

Basic Strengths : Devotion and Fidelity.

Up to this stage, according to Erickson, development mostly depends upon What is done to us. From here on out, development depends primarily upon what we do.

Adolescence - we are neither a child nor an adult.

Life is getting more complex.

6. Young adulthood : 18 to 35.

Ego Development Outcome : Intimacy and Solidarity v/s Isolation

Basic Strengths : Affiliation and Love.

At this stage of life we seek companions and friends.

Love, Relationship, Marriage, intimacy.

Unsuccessful Isolation.

8. Middle Adulthood : 35 to 55 or 65.

Ego Development Outcome : Generativity v/s Self absorption or stagnation.

Basic strengths : production and Care.

Crucial stage – Erikson observed that middle-age – creative and meaningful work, issues surrounding our family. Middle adulthood – in charge

Culture – taming the kids, establishing a stable environment. Generativity.

Major life changes - the mid-life crisis

Self-absorbed and stagnate.

Late Adulthood: 55 or 65 Death

Ego development Outcome : Integrity v/s despair.

Basic strengths: Wisdom.

Erikson felt that much of life is preparing for the middle adulthood stage and the last stage is recovering from it.

Happiness, life has a meaning, contribution to life, Erikson calls integrity.

I thank
you!

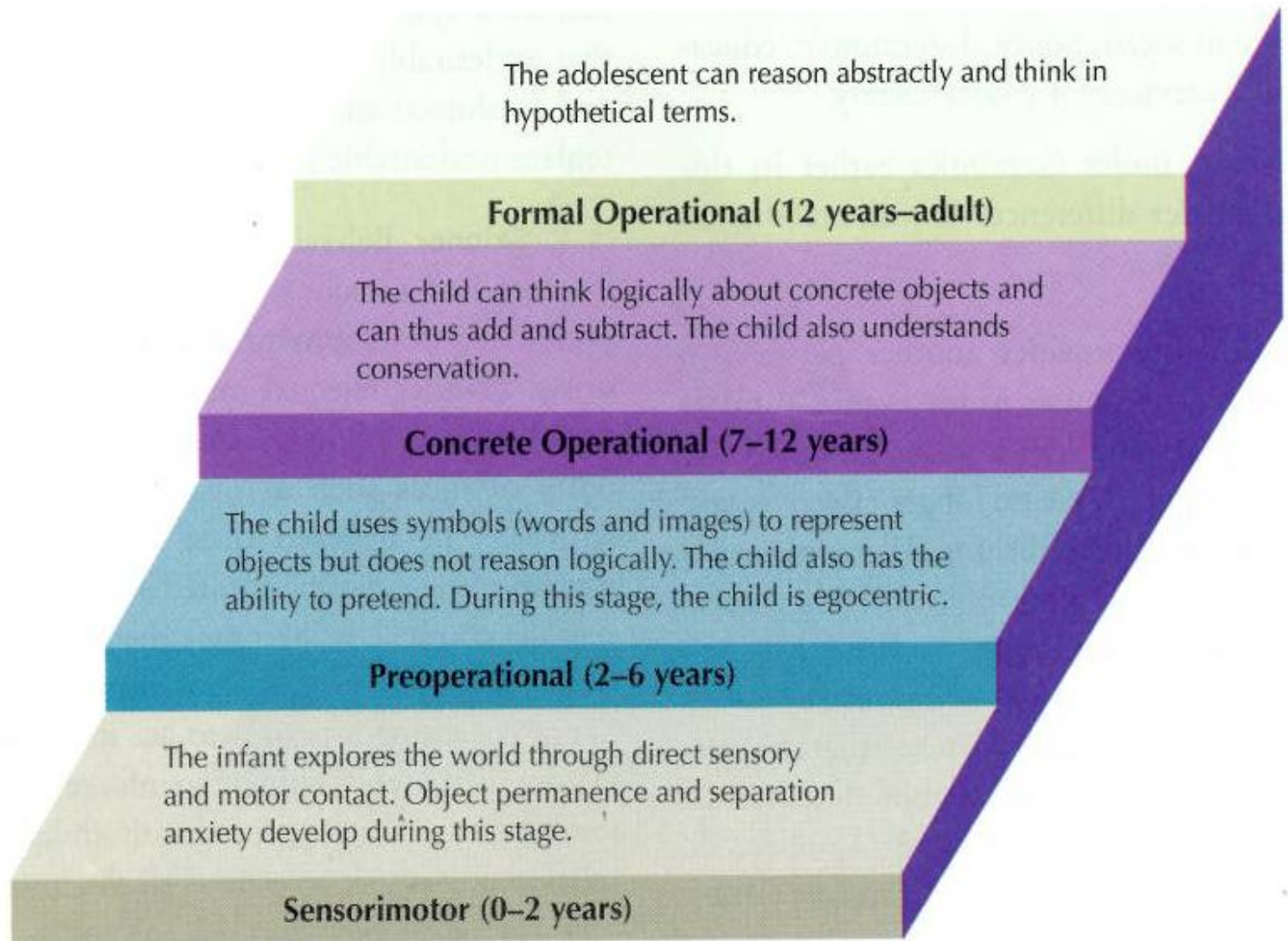


Jean Piaget stages of cognitive development

Aim: to explain Jean Piaget stages of cognitive development and how his findings can be applied in clinical areas.

Learning outcomes: (i) The learners will understand Piaget's stages of cognitive development and relate his findings to their nursing practice.

(ii) Learners working in pediatrics unit will have a better understanding of children's behaviour.



Piaget's stages of cognitive development. Piaget portrayed development as a staircase in which the different steps, or stages, are distinguished by specific kinds of thinking.

SOURCE: Kassin, S. (2001). *Psychology* (3rd ed.). Upper Saddle River, NJ: Prentice Hall. Used with permission.

Jean Piaget : Stages of Cognitive Development.

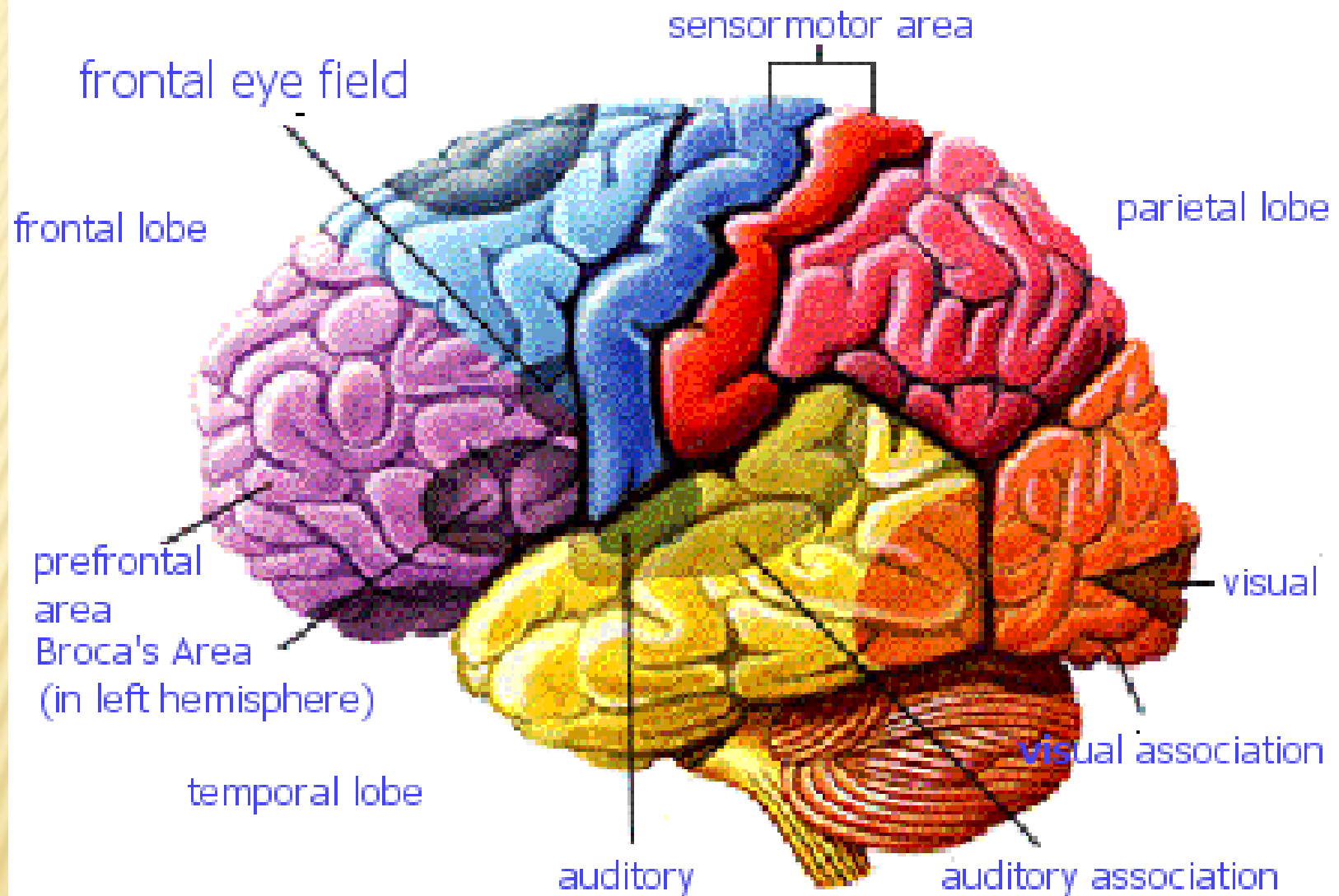
Piaget's work focuses on the intellectual development of the individual and his/her adaptation to the environment (Piaget and Inhelder, 1969 cited in Quinn p.63).

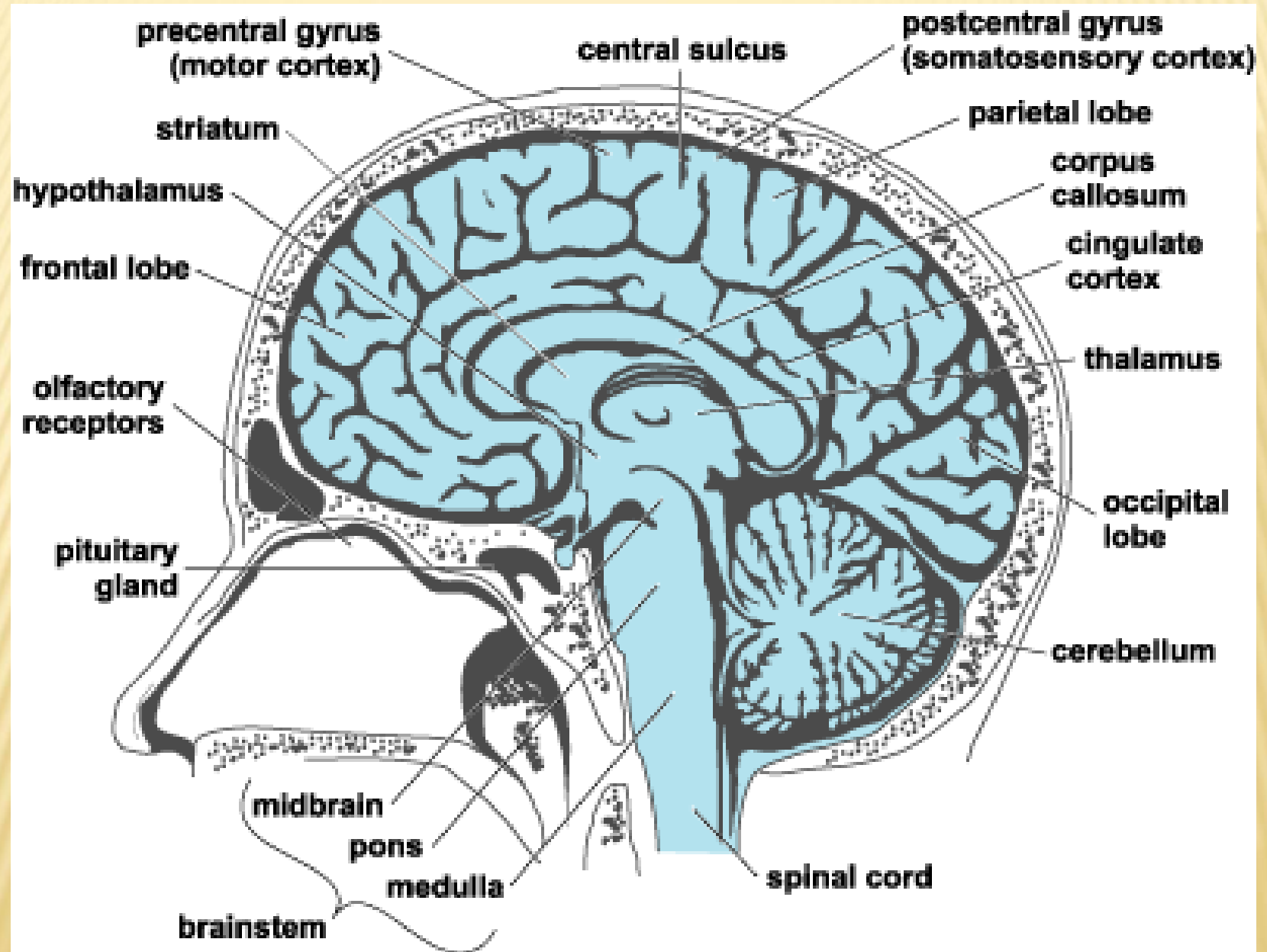
Piaget sees the child as an organism adapting to its environment, as well as a scientist constructing its own understanding of the world.

Research into the area of bio- and neuropsychology understanding is developing. Cognitive psychologists – the brain is an information processing unit like a computer. Brain – hard drive, mind – software.

Key influential areas in the development of the cognitive perspective are (Anderson 2000).

- Information theory
- Artificial intelligence
- Linguistics
- Neuroscience.





Endocrine system

The endocrine system is made up of glands that secrete hormones into the body. The major endocrine glands are shown in Table 1.1.

Biopsychologists study how each of these areas influence the behaviour of the person, in their search to understand that behaviour.

Endocrine glands and their principal effects. Adapted from Rosenzweig et al. 2005.

Gland	Principal effect
Pineal gland	Regulates seasonal changes and puberty
Hypothalamus	Regulates hormones released from pituitary gland
Pituitary gland	Produces a number of hormones which stimulate growth and development
Thyroid	Involved in metabolism and blood homeostasis
Adrenal glands	Regulates metabolism and body hair. Helps maintain blood sugar level
Pancreas	Involved in the metabolism of sugars
Gonads	Stimulate the development and maintenance of sexual characteristics and behaviour
Stomach	Involved in digestive processes
Heart	Promotes salt loss in urine

Cognitive Psychology

The cognitive perspective can be seen as an extension of the behaviorist perspective in that there is an acceptance that behaviour is learnt and that in any situation there is a stimulus and a response. The cognitive psychologists seek to understand what happens between stimulus and response because they recognize that there is not always a predictable automatic response to any given stimulus.

Schemas

The internal organization of an individual consists of schemas, which ways of giving meaning to, and dealing with, aspects of the environment that are encountered.

Assimilation - the process by which a person takes material into their mind from the environment, which may mean changing the evidence of their senses to make it fit. Dealing with the environment by making it fit with one's own existing mental structures, Piaget refers to as **assimilation**.

If the sucking reflex is taken as an example, then modification would include the adjustments made by the baby when he is fitting his mouth to the shape and size of the nipple or teat. Piaget refers to such adjustment as accommodation.

Accommodation - the difference made to one's mind or concepts by the process of assimilation. Note that assimilation and accommodation go together : you can't have one without the other.

A Schema

A schema for giving an injection would have fixed components:

- Needle
- Syringe
- Person to give injection to, etc.
- But it could also have flexible components :
- What medication is being injected ?
- Which part of the person the injection is being given into ?
- Environment in which injection is being given, etc.

The child's knowledge of the world is modified and extended by the processes of assimilation and accommodation and these processes are in balance with one another; Piaget calls this balancing process **equilibration – a dynamic process that prepares the child for new learning.**

Piagetian theory – motivation is intrinsic and arises from the application of schemas to the environment.

Stages of cognitive development

Cognitive development is seen by Piaget as consisting of four stages.

1. Sensorimotor stage (birth - 2 years)
2. Pre-operational stage (2-7 years)
3. Concrete operational stage (7 – 11 years)
4. Formal operational stage (12 years and up).

Sensorimotor stage (birth – 2 years)

At birth - infant is equipped only with basic reflexes and these serve as the first schemas – thinking = with doing.

Object permanence – demonstrates that a mental representation of the object must be present.

It indicates the beginnings of a move away from the egocentric focus of early infancy.

Pre-operational stage (2-7 years)

This stage is called pre-operational because the child is unable to use mental rules or operations for transforming information.

The child is still egocentric – focusing on general aspects instead of on the individual aspects of a situation.

Child's lack of conservation

Child 's lack reversibility – that is the ability to understand that if an operation is reversed it reverts back to its original state.

Concrete operation stage (7-11 years)

In this stage, the child develops conservation, and the ability to undertake mental operations. However, these operations are limited to the here-and-now; in other words, the child cannot reason **hypothetically**.

Formal operational stage (12 years and up)

This final stage is characterized by the ability of the child to reason hypothetically.

At each of these stages children think in quite different ways. They move from one stage to another through a maturational process.

Schema theory is a cognitive theory of how people might store information – memory.

It is suggested that new information is attached or becomes part of existing memory. A schema is a collection of information on a certain topic/area/thing. It has a fixed component but also has a flexible component.

Piaget's Key Ideas

Adaptation	What it says: adapting to the world through assimilation and accommodation
Assimilation	The process by which a person takes material into their mind from the environment, which may mean changing the evidence of their senses to make it fit.
Accommodation	The difference made to one's mind or concepts by the process of assimilation. Note that assimilation and accommodation go together: you can't have one without the other.
Classification	The ability to group objects together on the basis of common features.
Class Inclusion	The understanding, more advanced than simple classification, that some classes or sets of objects are also sub-sets of a larger class. (E.g. there is a class of objects called dogs. There is also a class called animals. But all dogs are also animals, so the class of animals includes that of dogs)
Conservation	The realisation that objects or sets of objects stay the same even when they are changed about or made to look different.
Decentration	The ability to move away from one system of classification to another one as appropriate.
Egocentrism	The belief that you are the centre of the universe and everything revolves around you: the corresponding inability to see the world as someone else does and adapt to it. Not moral "selfishness", just an early stage of psychological development.
Operation	The process of working something out in your head. Young children (in the sensorimotor and pre-operational stages) have to act, and try things out in the real world, to work things out (like count on fingers): older children and adults can do more in their heads.
Schema (or scheme)	The representation in the mind of a set of perceptions, ideas, and/or actions, which go together.
Stage	A period in a child's development in which he or she is capable of understanding some things but not others

Stages of Cognitive Development

Stage	Characterised by
Sensori-motor (Birth-2 yrs)	Differentiates self from objects Recognises self as agent of action and begins to act intentionally: e.g. pulls a string to set mobile in motion or shakes a rattle to make a noise Achieves object permanence: realises that things continue to exist even when no longer present to the sense (pace Bishop Berkeley)
Pre-operational (2-7 years)	Learns to use language and to represent objects by images and words Thinking is still egocentric: has difficulty taking the viewpoint of others Classifies objects by a single feature: e.g. groups together all the red blocks regardless of shape or all the square blocks regardless of colour
Concrete operational (7-11 years)	Can think logically about objects and events Achieves conservation of number (age 6), mass (age 7), and weight (age 9) Classifies objects according to several features and can order them in series along a single dimension such as size.
Formal operational (11 years and up)	Can think logically about abstract propositions and test hypotheses systemtically



Concept of health, wellness and illness

The aim of this session is to introduce the concept of health, wellness and illness and its impact people's health.

Learning Objectives:

- Learners will be able to differentiate between health, wellness and well-being.
- Learners will have an understanding of the models of health and wellness.
- Learners will be able to identify factors affecting health status, beliefs and practices.



Emotional Wellness

What is emotional wellness?

Emotional wellness is having a positive attitude, high self-esteem, a strong sense of self and the ability to recognize and share a wide range of feelings with others in a constructive way.



What are some signs of emotional wellness?

The ability to talk with someone about your emotional concerns and share your feelings with others.

Saying "no" when you need to without feeling guilty.

You feel content most of the time.

Feeling you have people in your life that care about you- a strong support network.

Being able to relax.

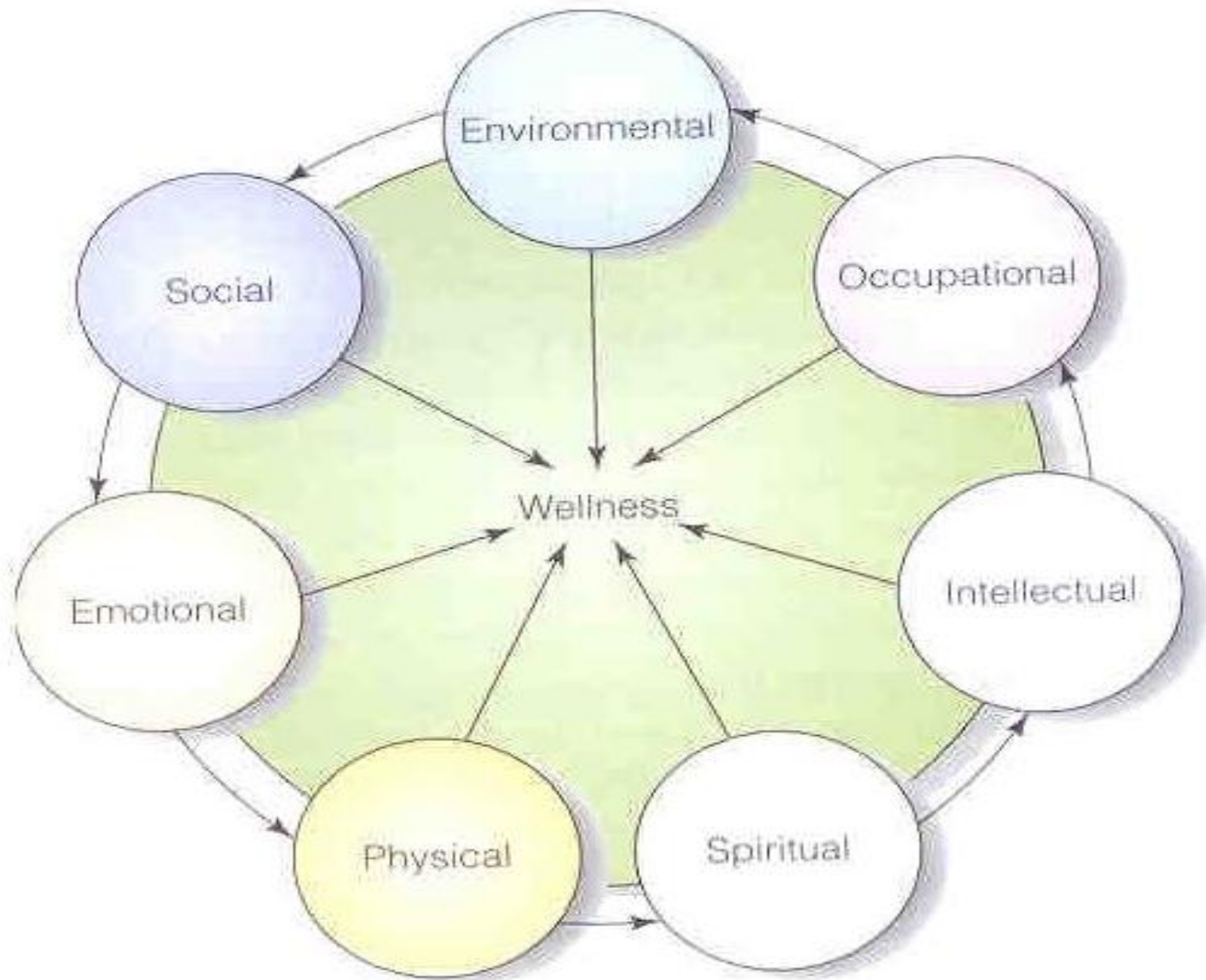
Feeling good about who you are.

MODELS OF HEALTH AND WELLNESS

Clinical Model

The narrowest interpretation of health occurs in the clinical model. People are viewed as physiological systems with related functions, and health is identified by the absence of signs and symptoms of disease or injury.

To laypeople it is considered the state of not being 'sick'. In this model the opposite of health is disease or injury.





**Spiritual
Wellness**



**Physical
Wellness**



**Mental
Wellness**



**Emotional
Wellness**

Self



**Social
Wellness**



**Environmental
Wellness**





Many medical practitioners use the clinical model in their focus on the relief of signs and symptoms of disease and elimination of malfunction and pain.

When these signs and symptoms are no longer present, the medical practitioner considers the individual's health restored.

Role Performance Model

Health is defined in terms of the individual's ability to fulfil societal roles, that is, to perform work.

According to this model, people who can fulfil their roles are healthy even if they appear clinically ill.

For example, a man who works all day at his job as expected is healthy even though an x-ray film of his lung indicates a tumour.

It is assumed in this model that sickness is the inability to perform one's work.

A problem with this model is the assumption that a person's most important role is the work role.

People usually fulfil several roles (e.g. mother, daughter, friend, and certain individuals may consider nonwork roles paramount in their lives.

Adaptive Model

The focus of the adaptive model is adaptation. In the adaptive model, health is creative process; disease is a failure in adaptation, or maladaptation.

The aim of treatment is to restore the ability of the person to adapt, that is, to cope.

According to this model, extreme good health is flexible adaptation to the environment and interaction with the environment to maximum advantage.

Roy's adaptation model of nursing (Roy, 1999) views the person as an adaptive system. The focus of this model is stability, although there is also an element of growth and change.

Murray and Zentner (2001) indicate this growth and change in their definition of health: 'a state of well-being in which the person is able to use purposeful, adaptive responses and processes, physically, mentally, emotionally, spiritually and socially, in response to internal and external stimuli (stressors) in order to maintain relative stability and comfort and to strive for personal objectives and cultural goals'.

Eudemonistic Model

Eudemonism is a system of ethics that evaluates actions in terms of their capacity to produce happiness.

The eudemonistic model incorporates a comprehensive view of health.

Health is seen as a condition of actualisation or realisation of a person's psychological potential.

Actualisation is the top of the fully developed personality, described by Abraham Maslow. In this model the highest aspiration of people is fulfilment and complete development which is actualisation.

Illness, in this model, is a condition that prevents self-actualisation.

Agent-Host-Environment Model

The agent-host-environment model of health and illness also called the ecologic model, originated in the community health work of Leavell and Clark (1965) and has been expanded into a general theory of the multiple causes of disease.

The model is used primarily in predicting illness rather than in promoting wellness, although identification of risk factors that result from the interactions of agent, host and environment are helpful in promoting and maintaining health.

The model has three dynamic interactive elements:

1. Agent

Any environmental factor or stressor (biological, chemical, mechanical, physical or psychosocial) that by its presence or absence (e.g. lack of essential nutrients) can lead to illness or disease.

2. Host

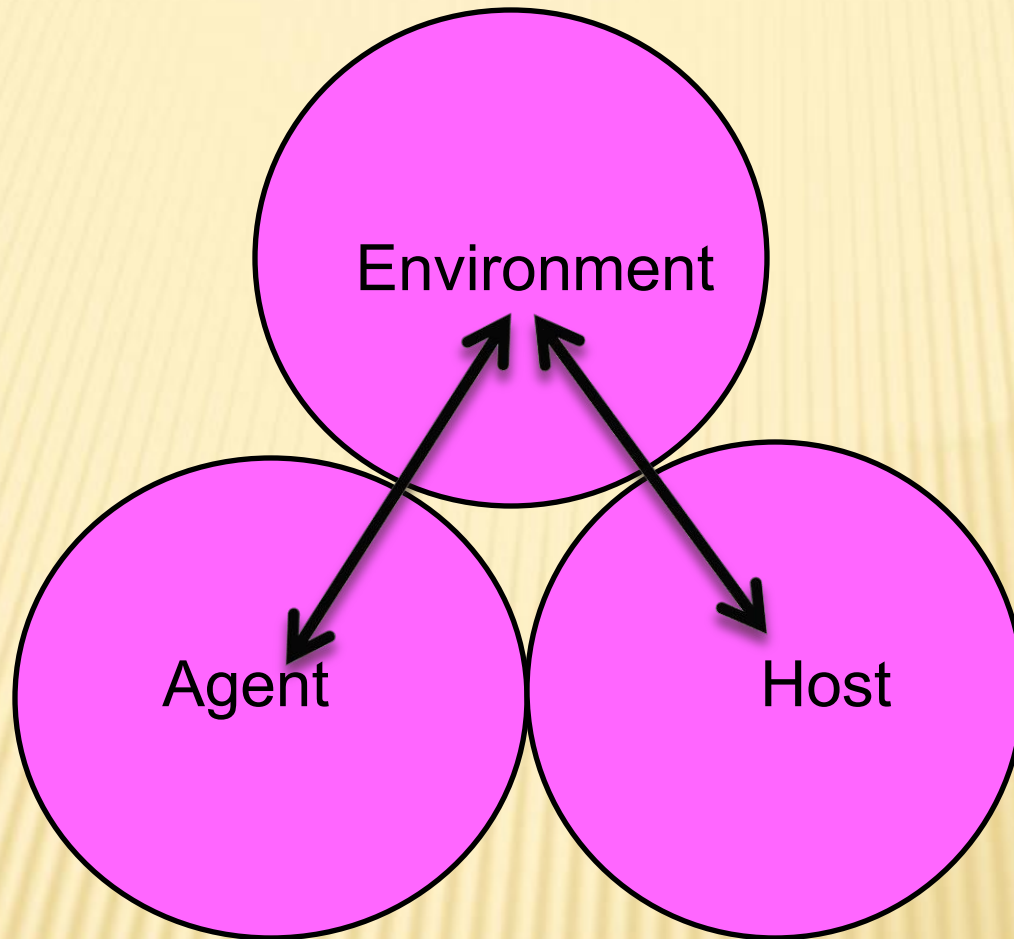
Person(s) who may or may not be at risk of acquiring a disease. Family history, age and lifestyle habits influence the host's reaction.

3. Environment

All factors external to the host that may or may not predispose the person to the development of disease.

Physical environment includes climate, living conditions, sound (noise) levels and economic level.

Social environment includes interactions with others and life events, such as the death of a spouse.



THE AGENT-HOST-ENVIRONMENT TRIANGLE

HEALTH-ILLNESS CONTINUA

Health-illness continua (graduated scales) can be used to measure a person's perceived level of wellness.

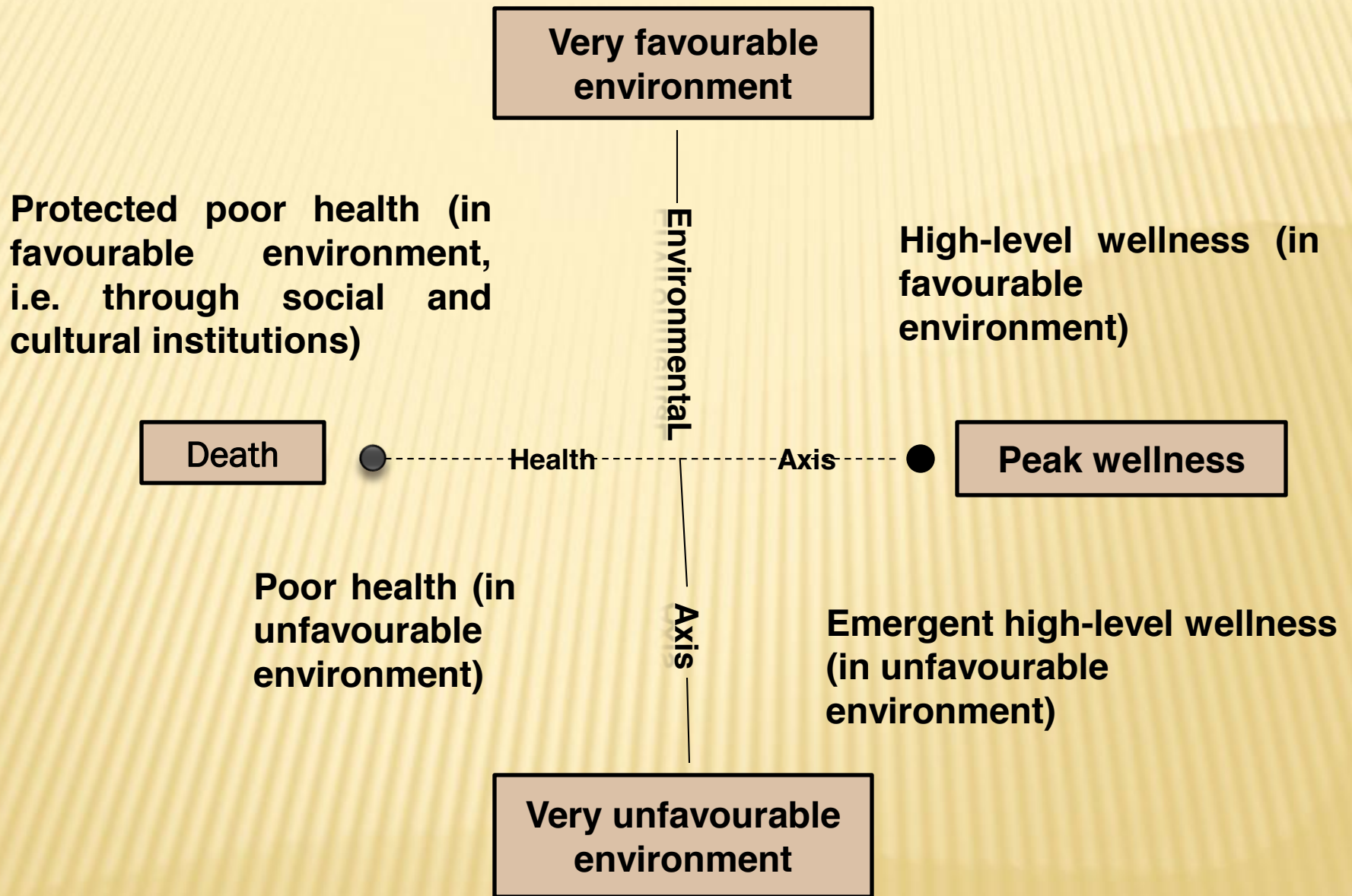
Health and illness or disease can be viewed as the opposite ends of a health continuum.

From a high level of health a person's condition can move through good health, normal health, poor health and extremely poor health, eventually to death.

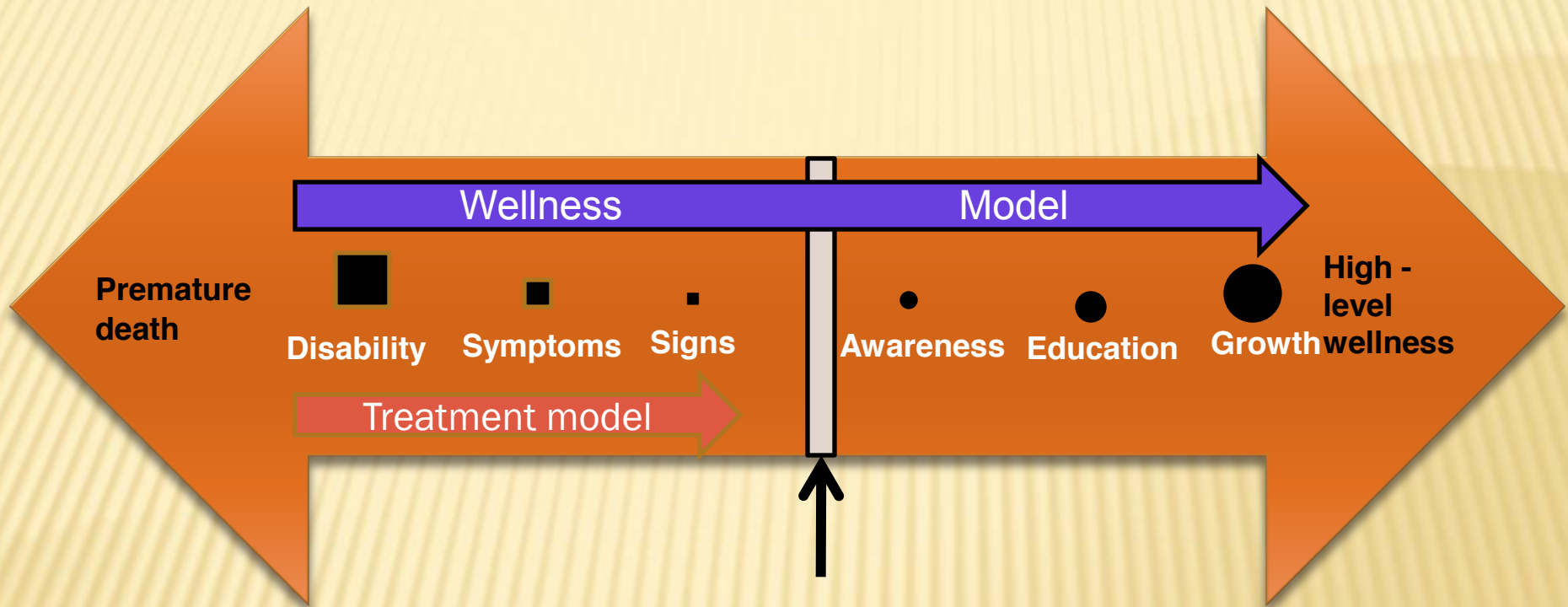
People move back and forth within this continuum day by day. There is no distinct boundary across which people move from health to illness or from illness back to health.

How people perceive themselves and how others see them in terms of health and illness will also affect their placement on the continuum.

The ranges in which people can be thought of as healthy or ill are considerable.



DUNN'S HEALTH GRID



Neutral Point
(No discernible illness or wellness)

ILLNESS-WELLNESS CONTINUUM

Internal Variables

Internal variables include biological, psychological and cognitive dimensions.

They are often described as nonmodifiable variables because, for the most part, they cannot be changed.

However, when internal variables are linked to health problems, the nurse must be even more diligent about working with the patient to influence external variables (such as exercise and diet) that may assist in health promotion and prevention of illness.

Regular health exams and appropriate screening for early detection of health problems become even more important.

Biological Dimension

Genetic makeup, sex, age and development level all significantly influence a person's health.

Genetic makeup influences biological characteristics, innate temperament, activity level and intellectual potential. It has been related to susceptibility to specific disease, such as diabetes and breast cancer.

In some cases, genetic predisposition for health or illness is enhanced when parents are from the same ethnic genetic pool.

For example, people of African heritage have a higher incidence of sickle-cell anemia and hypertension than the general population but may be less susceptible to malaria.

Sex influences the distribution of disease. Certain acquired and genetic diseases are more common in one sex than in the other.

Disorders more common among females include osteoporosis and autoimmune disease such as rheumatoid arthritis.

Those more common among males are stomach ulcers, abdominal hernias and respiratory diseases.

Age is also a significant factor. The distribution of disease varies with age. For example, arteriosclerotic heart disease is common in middle-aged males but occurs infrequently in younger people; such communicable diseases as whooping cough and measles are common in children but rare in older adults, who have acquired immunity to them.

Psychological developmental level has a major impact on health status. Consider these examples:

- + Infants lack physiological and psychological maturity so their defences against disease are lower during the first years of life.
- + Toddlers who are learning to walk are more prone to falls and injury.
- + Adolescents who need to conform to peers are more prone to risk-taking behaviour and subsequent injury.

- + Declining physical and sensory-perceptual abilities limit the ability of older adults to respond to environmental hazards and stressors.

Psychological Dimension

Psychological (emotional) factors influencing health include mind-body interactions and self-concept, which will now be discussed individually.

Mind-body interactions can affect health status positively or negatively. Emotional responses to stress affect body function.

For example, a student who is extremely anxious before an exam may experience urinary frequency and diarrhoea.

A person worried about the outcome of surgery or about the behaviour of a teenager may chain-smoke.

Prolonged emotional stress may increase susceptibility to organic disease or precipitate it. Emotional distress may influence the immune system through the central nervous system and endocrine alterations. Alterations in the immune system are related to the incidence of infections, cancer and autoimmune disease.

Increasing attention is being given to the mind's ability to direct the body's functioning. Relaxation, meditation and biofeedback techniques are gaining wider recognition by individuals and healthcare professionals.

For example, women often use relaxation techniques to decrease pain during childbirth. Other people may learn biofeedback skills to reduce hypertension.

Emotional reactions also occur in response to body conditions. For example, a person diagnosed with a terminal illness may experience fear and depression.

Self-concept is how a person feels about self (self-esteem) and perceives the physical self (body image), needs, roles and abilities.

Self-concept affects how people view and handle situations. Such attitudes can affect health practices, responses to stress and illness, and the times when treatment is sought.

An example is the anorexic woman who deprives herself of needed nutrients because she believes she is too fat even though she is well below an acceptable weight level.

Self-perceptions are also associated with a person's definition of health. For example, a 75-year-old man who can no longer move large objects as he was accustomed to do may need to examine and redefine his concept of health in view of his age and abilities, as he is no longer able to perform tasks in the same way.

Cognitive Dimension

Cognitive or intellectual factors influencing health include lifestyle choices and spiritual and religious beliefs.

Lifestyle refers to a person's general way of living, including living conditions and individual patterns of behaviour that are influenced by sociocultural factors and personal characteristics. In brief, lifestyle is often considered as behaviour and activities over which people have control. Lifestyle choices may have positive or negative effects on health.

Practices that have potentially negative effects on health are often referred to as **risk factors**. For example, overeating getting insufficient exercise and being overweight are closely related to the incidence of heart disease, arteriosclerosis, diabetes and hypertension.

Tobacco use is clearly implicated in lung cancer, emphysema and cardiovascular diseases.

Health promotion

According to Kemm and Close (1995 cited in Kozier et al 2008,p.110) health promotion is any activity that intends to prevent disease or promote health.

Health promotion is a process that enables individuals to control and change their lifestyles so that their health is improved. It is an activity that is done with and for people rather than done on or to them.



What is wellness? “Wellness is a multidimensional state of being describing the existence of positive health in an individual as exemplified by quality of life and a sense of well-being.” -Arizona State University's Charles B. Corbin.

Naidoo and Wills (2000 cited in Kozier et al 2008,p.110) - health promotion and illness prevention can be divided into three categories:

❖ **Primary prevention** that seeks to avoid the onset of disease by detecting those groups that are at increased risk of developing disease and providing them with information, advice and counseling (e.g. immunization).

❖ **Secondary prevention** that aims to shorten the episodes of illness and prevent progression of the disease (e.g. providing education healthy eating for diabetic patients).

❖ **Tertiary prevention** that aims to limit the effects and complications of the illness or disease process (e.g. rehabilitation for cardiac patients).

Definition of Disease Prevention

Disease prevention covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established.

Reference: adapted from Glossary of Terms used in Health for All series. WHO, Geneva, 1984

Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seeks to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation.

Disease prevention is sometimes used as a complementary term alongside health promotion. Although there is frequent overlap between the content and strategies, disease prevention is defined separately. Disease prevention in this context is considered to be action which usually emanates from the health sector, dealing with individuals and populations identified as exhibiting identifiable risk factors, often associated with different risk behaviors.

Health maintenance, a systematic program or procedure planned to prevent illness, maintain maximum function, and promote health. It is central to health care, especially to nursing care at all levels (primary, secondary, and tertiary) and in all patterns (preventive, episodic, acute, chronic, and catastrophic).

Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.

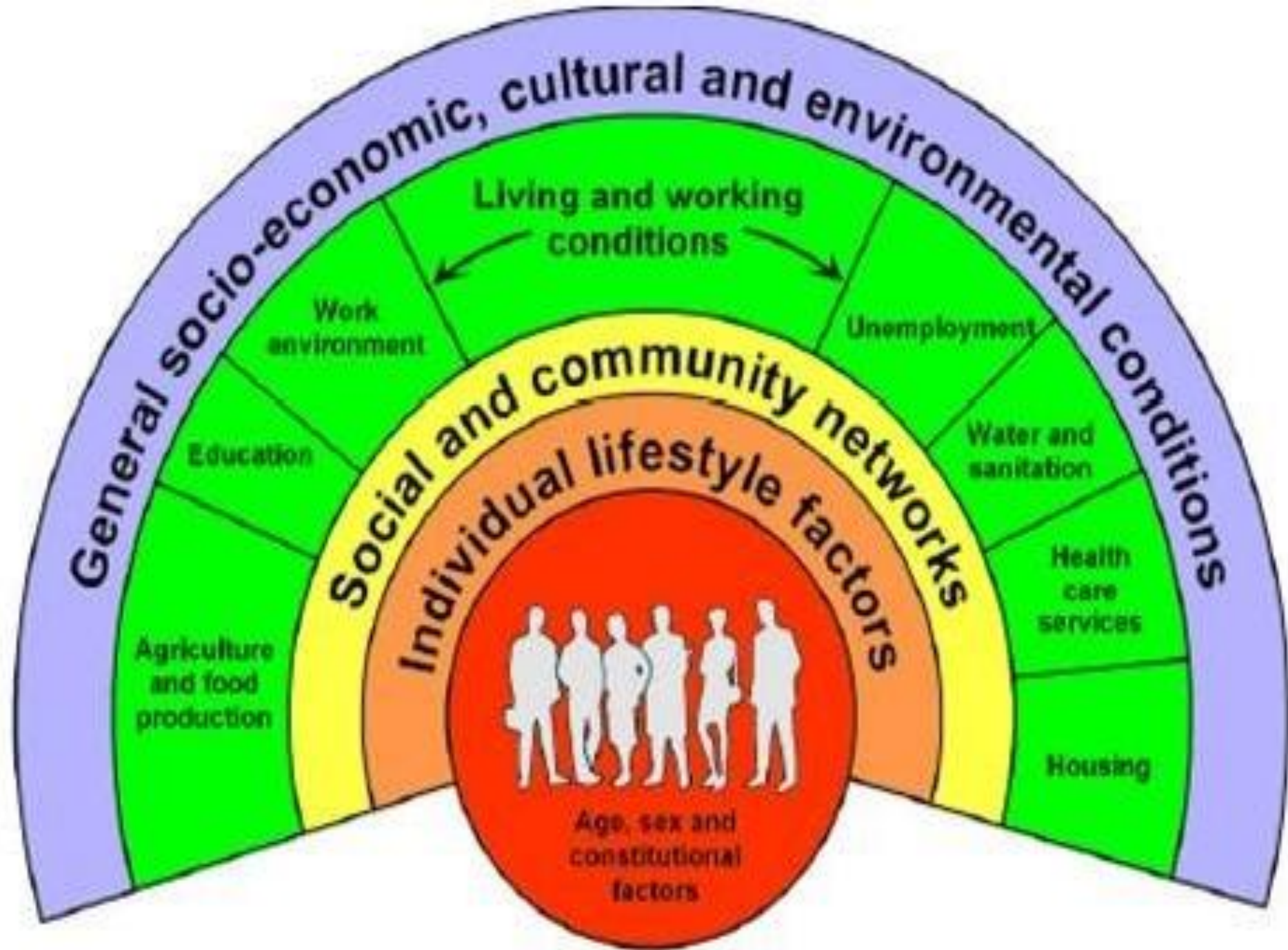
Definition: Curative care refers to treatment and therapies provided to a patient with an intent to improve symptoms and cure the patient's medical problem. Antibiotics, chemotherapy, a cast for a broken limb -- these are examples of curative care.

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible.

Purpose

The purpose of rehabilitation is to restore some or all of the patient's physical, sensory, and mental capabilities that were lost due to injury, illness, or disease. Rehabilitation includes assisting the patient to compensate for deficits that cannot be reversed medically. It is prescribed after many types of injury, illness, or disease, including amputations, arthritis, cancer, cardiac disease, neurological problems, orthopedic injuries, spinal cord injuries, stroke, and traumatic brain injuries. The Institute of Medicine has

It is prescribed after many types of injury, illness, or disease, including amputations, arthritis, cancer, cardiac disease, neurological problems, orthopedic injuries, spinal cord injuries, stroke, and traumatic brain injuries. The Institute of Medicine has estimated that as many as 14% of all Americans may be disabled at any given time. Available from: <http://medical-dictionary.the-free-dictionary.com/rehabilitation>.







I thank
you!



Case Study

David is 50 years old and has been admitted to your care. Sarah, his daughter, asks you to explain why her father, who has been recently diagnosed with Chronic Obstructive pulmonary Disease (COPD), which is a chronic condition, has been admitted with an acute infection. Although he has this chronic illness he normally feels fit and well and cannot understand why he feels so unwell at the moment.

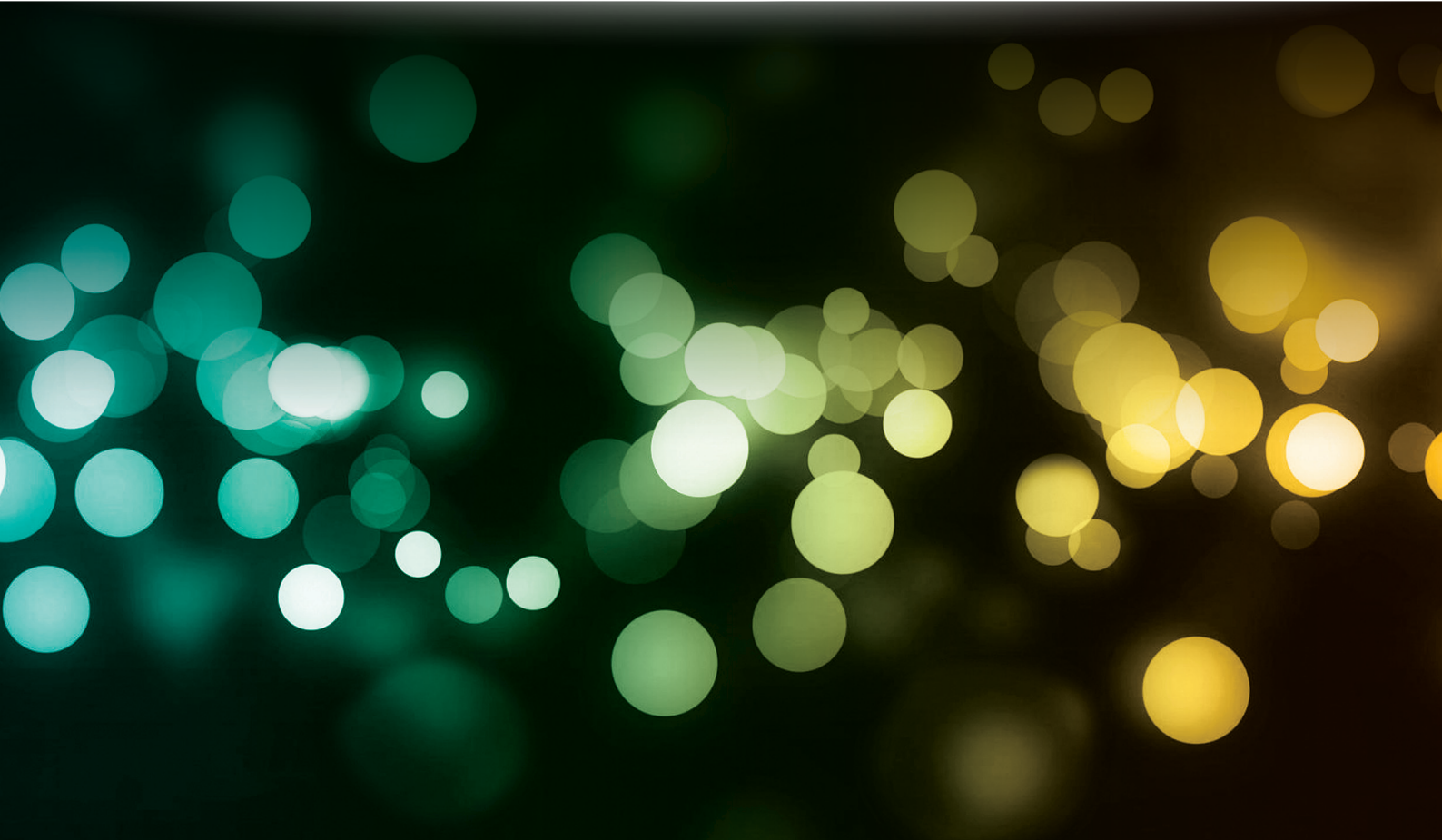
As you discuss with Sarah you discover that Davis is not taking his prescribed medications as he does not believe in taking tablets.

As you explain the differences between chronic and acute illness, you also explain the need to adhere to prescribed medications by using health belief models.

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CONTENTS

- 1 Nursing
- 9 Mental Health Nursing
- 11 Healthcare
- 13 Healthcare Case Books
- 14 Midwifery
- 15 Dementia & Later Life
- 17 Understanding Public Health
- 20 Public Health
- 21 Paramedic Care
- 23 Research Methods
- 26 Continuing Professional Development
- 27 Child & Adult Protection
- 29 Management & Policy
- 31 Health Psychology & Counselling
- 32 Study Skills
- 33 Index

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It's an exciting time to be a Nurse or a Health Professional. At Open University Press we are working hard to ensure that our new books provide you with the information and resources you need to offer excellent care and be completely up-to-date.

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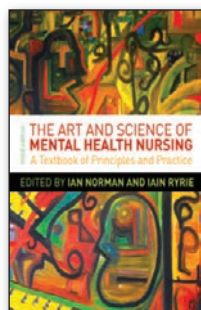
- A third edition of *The Art and Science of Mental Health Nursing*. This new edition has 7 new chapters and new contributors from a range of experts.
- A second edition of *A Beginner's Guide to Evidence-Based Practice in Health and Social Care*. This popular book has lots of new content to help you get to grips with EBP.
- A brand new book on *Competencies for Nursing Practice* which shows student nurses how to ensure they meet the NMC competencies.
- We have two new books for the Non-medical Prescribing market including *Nurses! Test Yourself in Non-medical Prescribing* and a case book on medicines management, which are both perfect for exam preparation.

We are constantly on the look-out for new ideas and we would be delighted to hear from you if you are interested in writing for Open University Press.

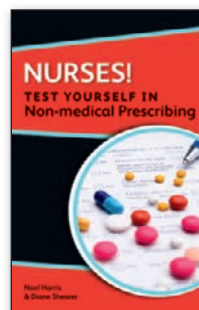
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Rachel Crookes, Senior Commissioning Editor (rachel_crookes@mcgraw-hill.com)

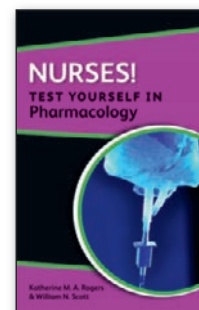
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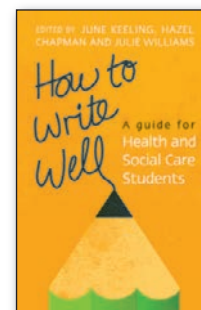
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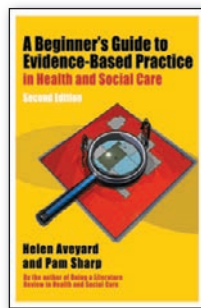
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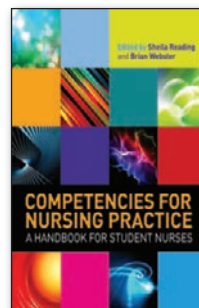
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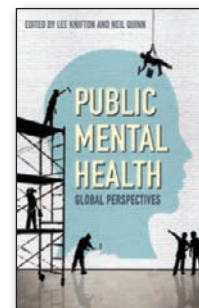
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Pg 7



Pg 1



Pg 9



Pg 24

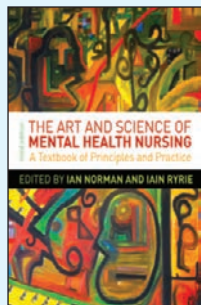
Designed by Naomi Mitchell

NEW EDITION

The Art and Science of Mental Health Nursing 3/e Principles and Practice

Ian Norman and
Iain Ryrie (Eds)

King's College London, UK;
Practising Nurse, UK



This comprehensive and bestselling nursing text has been fully and extensively

updated for this third edition, and offers students a complete guide to the art and science of mental health nursing. The book combines theory and practice to look in-depth at:

- Different 'types' of mental health problems
- Different therapeutic interventions
- The practical tools of nursing such as risk, assessment, problem solving
- Key themes such as ethics, law and professional issues

Fully updated by the editors and with a host of new contributing authors, this edition has seven brand new chapters. It includes:

- Expanded coverage of psychological interventions
- More emphasis on the skills and capabilities required by nurses in mental health nursing
- An updated evidence base including latest intervention evidence of what works in mental health nursing
- New chapters on: admission and discharge, group work, family and carers, solution focused approaches, counselling approaches, motivational approaches, older adults with functional illness, CPD
- Additional case studies and practice examples to help students reflect as they learn
- Contributions from service users and carers

Contents: Part 1: Foundations / Part 2: Contexts / Part 3: Core procedures / Part 4: Interventions / Part 5: Client groups / Part 6: Future directions

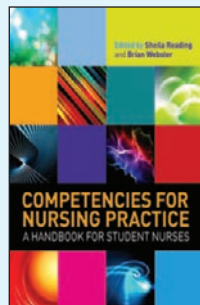
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NEW

Competencies for Nursing Practice A Handbook for Student Nurses

Sheila Reading and
Brian James Webster (Eds)
University of Southampton,
UK; Edinburgh Napier
University, UK



Achieving the NMC competencies is an ongoing requirement that nurses work towards across

all three years of pre-registration study. This book illuminates what students need to understand about each of the competencies and illustrates how best to achieve them in training and practice.

The book is divided into several sections, considering in turn:

- Professional values
- Communication and interpersonal skills
- Decision making
- Leadership
- Working with mentors

Each chapter tackles a different competency, and uses activities and examples to help readers get to grips with the competency and relevant NMC requirements. The book is very interactive and offers lot of portfolio activities for students to use to demonstrate competency as they build a portfolio of evidence.

Written by an expert team of nurse lecturers based at Southampton and Robert Gordon University, this exciting and comprehensive text offers student nurses a one-stop-shop for developing their professional practice skills as they prepare for qualification.

Contents: Part 1: Professional values / Part 2: Communication and interpersonal skills / Part 3: Decision making in practice / Part 4: Leadership, management and team working / Part 5: Opportunities to explore the development of competencies

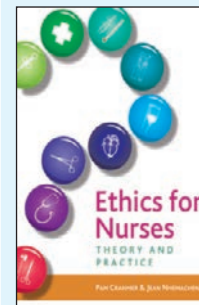
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NEW

Ethics for Nurses Theory and Practice

Pam Cranmer and
Jean Nhemachena
Both at the University of
Huddersfield, UK



Ethics underpin all aspects of nursing activity, and this book has been written to help student nurses explore and explain key aspects of ethical nursing practice. Using plentiful

examples and case studies, this user friendly book introduces key concepts in ethics and shows how to apply them to everyday nursing practice.

The book helps readers explore questions such as:

- What are rights?
- What is dignity?
- How are nurses accountable?
- How does the law relate to ethics?
- What is a dignified death?

The authors have created a fictional set of characters who appear throughout the book and experience various healthcare dilemmas and scenarios. These characters help illustrate different aspects of ethics in healthcare and bring ethical concepts and decision making to life so that readers can see ethics in action.

Contents: What is ethics? An introduction / What must nurses do? / Should consequences be considered? / Why are respect and autonomy so important in health care? / What is fairness in care? / What are rights? / What is dignity? / Are nurses accountable ethically? / How does law relate to ethics 'The special case of the duty of care'? / What is a dignified death? / What is ethical research?

Paperback £19.99
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BESTSELLER

Psychology for Nurses and the Caring Professions 4/e

Jan Walker, Sheila Payne, Nikki Jarrett and Tim Ley
University of Southampton; Lancaster University; University of Southampton; University of Plymouth, UK

"I would highly recommend this text to any student studying psychology as part of the CFP or later years and to qualified nurses with an interest in psychology. It is ... a book dedicated to the nursing professions most important aspect; understanding our patients needs."

S. A. Hough, *First Year Nursing Student*

This bestselling book introduces students and practitioners to psychological knowledge and understanding for clinical contexts, emphasizing the ways that psychological theory and research may be used to enhance caring and compassion.

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How to do a Systematic Literature Review in Nursing A Step-By-Step Guide

Josette Bettany-Saltikov
University of Teesside, UK



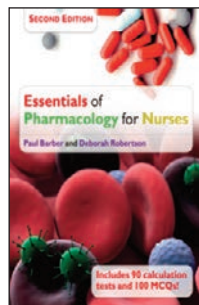
From writing your review

question to writing up your review, this practical book is the perfect workbook companion if you are doing your first literature review for study or clinical practice improvement. The book features two sample review case studies to help identify good practice as well as the pitfalls to avoid, and the practical explanations will be invaluable at every stage.

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BESTSELLER



Essentials of Pharmacology for Nurses 2/e

Paul Barber and Deborah Robertson
Both at the University of Chester, UK

"Paul Barber and Deborah Robertson have put together a fabulous, informative and valuable book that addresses one of nursing's key roles. The text presents pharmacology for nurses in a

clear and easy to read style ... this is a book that will stimulate and motivate."

Valerie McGurk, *Nursing Standard*

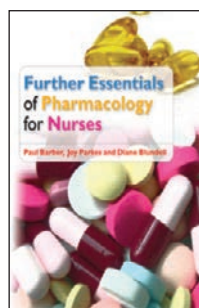
This accessible book introduces pharmacology and calculations in a friendly, informative way and is now updated throughout with new topics and new coverage of more drugs and issues.

The book focuses on the pharmacology knowledge needed at pre-registration level and does not assume previous knowledge of pharmacology, or a level of confidence with maths and drugs calculations.

Barber and Robertson build on your existing knowledge of anatomy and physiology to help give a holistic understanding of body systems.

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Further Essentials of Pharmacology for Nurses

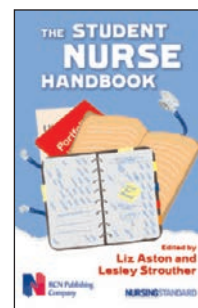
Paul Barber, Joy Parkes and Diane Blundell
All at the University of Chester, UK

This book follows on from the bestselling book *Essentials of Pharmacology for Nurses*, and is aimed at pre-registration nursing students looking for an accessible guide to drug

groups that goes beyond the essentials.

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The Student Nurse Handbook

Liz Aston and Lesley Strouther
Both at the University of Nottingham, UK



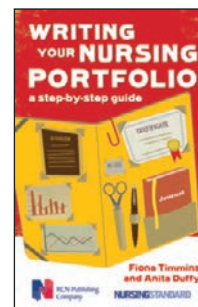
Undertaking a pre-registration nursing course is an intense and unique experience.

Written by student nurses, this concise book offers advice and insights in to the key issues and challenges that new students will face when they commence their course. It includes:

- What to expect from the course
- Coping with placements
- Getting on with your mentor
- How to write portfolio entries
- What you can and can't do in practice
- Tips and advice for assessment
- How to plan your nursing career

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Writing Your Nursing Portfolio A Step-By-Step Guide

Fiona Timmins and Anita Duffy
Both at Trinity College Dublin, Ireland



"I am delighted to endorse this practical and accessible guide to writing and developing a portfolio for nurses. Unlike many 'how-to-do' approaches to portfolio compilation, this book acknowledges the complexity involved in learning from practice, and recording that learning in a meaningful way."

Professor Melanie Jasper, *Swansea University, UK*

This handy guide, co-published with the *Nursing Standard*, is perfect for nurses who need to put together a portfolio and don't know where to start.

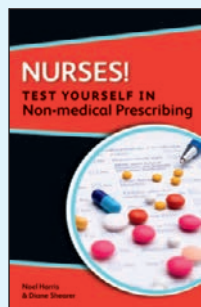
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Nurses! Test Yourself Series

This series of exam preparation books are perfect for helping nursing students revise for exam assessments. These test books are sure to help students improve their results and tackle exams with confidence!

NEW



Nurses! Test Yourself in Non-medical Prescribing

Noel Harris and
Diane Shearer
University of Northampton, UK;
Anglia Ruskin University, UK

"I would like to congratulate the authors on an excellent revision aid. The resources identified along with the

questions designed to test students knowledge, provides an excellent text for students on the prescribing program."

Molly Courtenay, Professor of Clinical Practice at the University of Surrey, UK

This handy book is the essential self-test resource for nurses studying for a non-medical prescribing qualification and preparing for exams. It covers a range of topics vital to the role of non-medical prescribing including: pharmacology, legal and ethical issues, decision making, consultation skills, drug licensing and handling, adverse drug reactions and drug calculations. The book includes over 450 questions with full answers and explanations and will help you improve your results and tackle your exams with confidence!

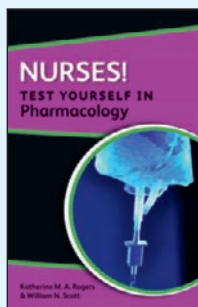
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NEW



Nurses! Test Yourself in Pharmacology

Katherine Rogers
Queen's University Belfast, UK

This book is designed as a revision and study aid for student nurses undertaking their pharmacology module / s and related exam assessment. It is a self-test book of self-assessment questions and quizzes that is designed to

both test students learning and help them tackle their knowledge gaps by explaining the answers to all the questions included.

The text is organised into body systems chapters and each chapter includes the following types of questions:

- True or false questions
- Multiple choice questions
- Fill in the blank and match the terms
- Match the terms

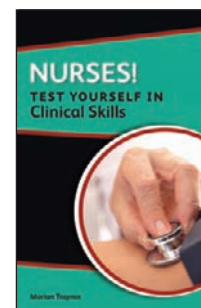
Within each chapter, all the answers are given and then explained - so the book can be used both for self-testing and more constructive revision. A must have!

Contents: Introduction to pharmacology and drug administration / Drugs associated with inflammation and infection / The integumentary system / The musculoskeletal system / The nervous system / The endocrine system / The circulatory system / The respiratory system / The digestive system / The urinary system / Pharmacological treatment of cancer / Drug treatment in children and older adults / Drug poisoning and its treatment / Glossary and terms commonly used in nursing science and pharmacology

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Nurses! Test Yourself in Clinical Skills

Marian Traynor (Ed)
Queen's University Belfast, UK

"This well presented and pragmatic book ... is an effective tool to assist with revision of clinical skills. It allows students to test their knowledge in a variety of standalone topics, such as

risk assessment and medication management. I believe nursing students will find it a very valuable resource."

Linzi McIlroy, Senior Professional Development Officer, Royal College of Nursing, Northern Ireland, UK

This handy reference book is the essential self-test resource for nurses studying clinical skills and preparing for exams.

The book contains more than 300 test questions and 50 glossary terms including:

- Labelling test questions
- True or false questions
- Multiple choice questions
- Fill in the blank questions

Skills covered include:

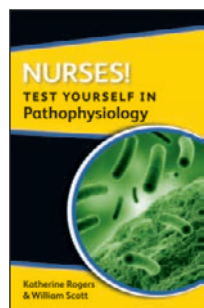
- Infection control
- Respiratory skills
- Cardiovascular skills
- Neuro assessment skills
- Early warning scores (observations)
- Drug administration
- Fluid and nutritional skills
- Elimination skills
- Diabetes mellitus skills
- Risk assessment

Full answers and explanations are given within each chapter so the book can be used both for self-testing and for more constructive revision including preparation for OSCEs.

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Nurses! Test Yourself in Pathophysiology

Katherine Rogers and
William Scott
Queen's University Belfast;
Letterkenny Institute of
Technology, UK

*"This book provides
extensive coverage of each
of the human body systems.
It relates pathophysiology*

*to the clinical environment, relevant investigations
and treatments for disease. A useful text for both
newly qualified and student nurses."*

Amy Hutchinson, Student Nurse, University of
Ulster, UK

*"This book contains a substantial bank of
questions which will prove very useful to any
enthusiastic student wishing to actively learn and
revise pathophysiology. The simple structure and
expanded answers provide effective feedback,
adding value and support for learning. The book
will be a useful partner to support many of the
pathophysiology textbooks currently available. It
should be included on recommended reading lists
for students. It will also find a useful place in
support of teaching and professional
development."*

Jim Jolly, Head of Academic Unit for Long Term
Conditions, School of Healthcare, University of Leeds,
UK

This handy book is the essential self-test resource to
help nurses revise and prepare for their
pathophysiology exams.

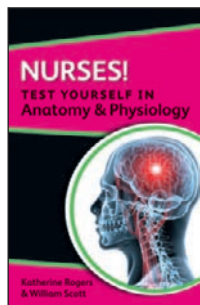
The book covers a broad range of conditions
common to nursing practice including pneumonia,
diabetes, asthma, eczema and more. It includes over
300 questions and 70 glossary terms in total, and
each chapter has:

- Multiple choice questions
- True or false questions
- Labelling exercises
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BESTSELLER



Nurses! Test Yourself in Anatomy and Physiology

Katherine Rogers and
William Scott
Queen's University Belfast;
Letterkenny Institute of
Technology, UK

*"This book is the perfect
companion to help nurses
explore their own
understanding of this key*

*subject. Students and newly qualified nurses alike
will find the different kinds of tests a valuable
revision aid."*

James Pearson-Jenkins, Senior Lecturer of Adult Acute
Nursing, University of Wolverhampton, UK

*"Now the student has a resource that actually
guides them towards success. It will complement
any course that includes introductory A&P. This
book will be a very useful partner to any student
new to the subject that is motivated to learn and
do well."*

Jim Jolly, Head of Academic Unit for Long Term
Conditions, School of Healthcare, University of
Leeds, UK

This handy book is the essential self-test resource for
nurses studying basic anatomy and physiology and
preparing for exams.

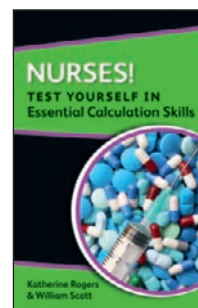
This book includes over 450 questions in total, each
with fully explained answers. These include:

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- 180 glossary terms
- Multiple choice questions
- True or false questions
- Labelling exercises
- Fill in the blank questions

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Nurses! Test Yourself in Essential Calculation Skills

Katherine Rogers and
William Scott
Queen's University Belfast;
Letterkenny Institute of
Technology, UK

*"This book will be of great
benefit to student nurses."*

*Following the clear, step by step guides and
worked examples will enable you to quickly
develop the confidence to master more complex
processes. It will also be an invaluable resource for
mentors supporting students."*

Dorothy Adam, Lecturer, The Robert Gordon
University, UK

*"This book is a useful tool for all nurses. I would
recommend it for nursing staff undertaking
intravenous or other medication management
courses / modules. It would also benefit nurses
who have to undertake calculations tests as part
of their new post or ongoing development."*

Amy Hutchinson, Student Nurse, University of Ulster, UK

Calculation exams can intimidate many nurses. This
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With more than 500 test questions in total, the
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- Quick reference tables of common units, formulae
and times tables

There are also chapters on the most common drug
administrations used in nursing. The book shows you
how to use calculations in clinical settings.

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Case Book Series

This new series of case books is written for nursing and other allied health profession students. They are designed to help students link theory and practice and provide an engaging and focused way to learn.

Medicine Management for Nurses Case Book

Paul Barber (Ed)
University of Chester, UK

This case book covers the principles and skills involved in a range of medicine management scenarios and will help nursing students integrate their knowledge of physiology, pathophysiology, pharmacology and nursing care. Including 21 case studies, each case gives readers the opportunity to learn about effective medicine management while testing their knowledge and understanding of essential drug groups.

Contents: *The person with Alzheimer's disease / The young person with asthma / The person with bi-polar disorder / The person with lung cancer / The person with COPD / The person with congestive cardiac failure / The child with cystic fibrosis / The person with depression / The child with diabetes (insulin dependent) / The adult with diabetes (non-insulin dependent) / The person with epilepsy / The person with hypertension / The person with inflammatory bowel disease / The child with meningitis / The person with myocardial infarction / The woman with osteoporosis / The person in pain / The person with Parkinson's disease / The person with rheumatoid arthritis / The person with schizophrenia / The woman with a urinary tract infection*

Paperback £22.99
August 2013 240pp

ISBN: 978-0-335-24575-8
eBook: 978-0-335-24576-5
amazonkindle CourseSmart*

NEW

Learning Disabilities in Health Care Settings Case Book

Bob Hallawell (Ed)
University of Nottingham, UK

This book for learning disability nurses comprises 22 different case studies relating to learning disabilities in health care. The case studies give an opportunity to learn about different aspects of good quality care giving in the learning disability field, plus a chance for students and practitioners to test their understanding. Each case features questions and answers on a range of topics from physiology to professional skills, ethical dimensions to communication skills – all designed to help students develop their care giving skills and prepare for exams or essay based tests.

Contents: *Section 1: Understanding learning disabilities – Origins and contemporary practice / Section 2: Childhood and adolescence / Supporting the family who have a child with a learning / intellectual disability / Respite care for children and adults / Child and adolescent mental health / Gender identity and sexuality / Transition / Safeguarding children / Communicating with children / Section 3: Adulthood / Working with challenging behaviours / Health facilitation / Advocacy and self advocacy / Bullying and harassment / Women, pregnancy and parenting / Living with Downs Syndrome / Sexuality and relationships / Legislation and care / Autistic spectrum disorder / Epilepsy / Supporting diversity / Adult mental health / Personality disorder / Dementia / End of life care / Bereavement*

Paperback £19.99
December 2013 240pp

ISBN: 978-0-335-24307-5
eBook: 978033524308-2
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NEW

Perioperative Practice Case Book

Paula Strong and Suzanne J Hughes (Eds)
Both at Cardiff University, UK

This book comprises numerous case studies in the field of perioperative practice and is designed to help students revise and prepare for exams. Each case study includes:

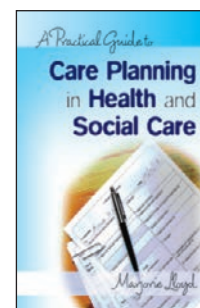
- Full case study background including patient presentation, histories and clinical information
- Questions relating to physiology, pathophysiology, clinical procedures and other aspects of perioperative practice
- Fully explained answers that include clinical charts, diagrams and figures and good clinical overviews

In addition to case studies the authors provide several chapters offering an overview of assessment within perioperative practice. These case studies are ideal for exam preparation, and to help students link theory to practice and apply it to real life scenarios.

Contents: Chapters: *Principles of assessment / Handover / Principles of patient assessment / Procedure assessment / Anaesthetic assessment / Resource assessment / Cases: General surgery / Gynaecology / Trauma / Orthopaedic / Spinal / Neurological / Cardiac / Thoracic / Urology / Breast / Vascular / ENT / Maxillofacial / Paediatric / Oncology / Obstetric / Bariatric Surgery*

Paperback £21.99
December 2013 232pp

ISBN: 978-0-335-24503-1
eBook: 978-0-335-24504-8
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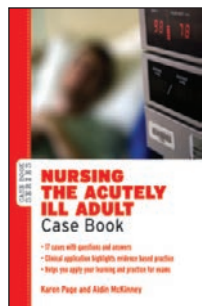
Paperback £19.99
2010 160pp

A Practical Guide to Care Planning in Health and Social Care

Marjorie Lloyd (Ed)
Glyndwr University, UK

The book explores the care planning process in detail and provides opportunities to reflect upon practice and to develop effective skills.

ISBN: 978-0-335-23732-6
eBook: 978-0-335-24991-7
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Nursing the Acutely Ill Adult Case Book

Karen Page and
Aiden McKinney
Both at Queen's University Belfast,
UK

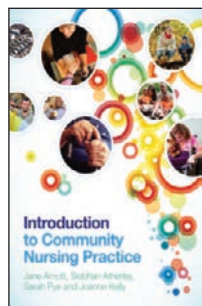
"It is an ideal reference resource for nurses who wish to reflect and explore the evidence base underpinning the complexities of nursing acutely ill adults."

Alison Eddleston, Senior Lecturer Acute, University of Central Lancashire, UK

Part of a case book series, this accessible book contains 17 in-depth case studies relating to care of the acutely ill adult. The cases combine pathophysiology, pharmacology and nursing care in realistic clinical settings, providing an engaging resource for nursing students taking acute care modules.

Paperback £21.99
2012 200pp

ISBN: 978-0-335-24309-9
eBook: 978-0-335-24310-5
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Introduction to Community Nursing Practice

Jane Arnott, Siobhan Atherley,
Sarah Pye and Joanne Kelly
All at Canterbury Christ Church
University, UK

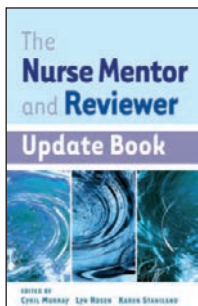
This textbook is perfect for understanding how community nursing works, and how to work effectively in community settings. The skills

required to work with the challenges of community nurse activities are clearly introduced, from working in people's homes, working with carers, developing assessment skills to working with other professionals.

By drawing on vivid case studies set in the fictional town of Chettlesbridge, the authors skilfully bring to life the world of community nursing practice enabling you to apply new learning to real situations.

Paperback £22.99
2012 224pp

ISBN: 978-0-335-24471-3
eBook: 978-0-335-24472-0
amazonkindle CourseSmart



The Nurse Mentor and Reviewer Update Book

Cyril Murray, Lyn Rosen and
Karen Staniland (Eds)
All at The University of Salford, UK

Using case studies and examples based on the specific Nursing and Midwifery Standards (NMC 2008) the book supports qualified mentors towards

meeting the evidence requirements of an annual mandatory update.

A range of activities are included that can be worked through individually by a mentor or with peers. These will help to provide a range of different sources of evidence at appraisal interviews, to demonstrate a mentor's ongoing competence.

Paperback £19.99
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ISBN: 978-0-335-24119-4
eBook: 978-0-335-24121-7
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The Student Nurse Guide to Decision Making in Practice

Liz Aston, Jill Wakefield and Rachel McGown (Eds)
All at The University of Nottingham, UK

This text introduces key concepts around decision making in clinical practice, and is a practical book for use from years 1-3. The book includes lots of portfolio activities for you to try while on placement, and gives tips and advice on how best to work with your mentors and as part of a healthcare team.

Paperback £19.99
2010 160pp

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Succeed in OSCEs and Practical Exams

An Essential Guide for Nurses

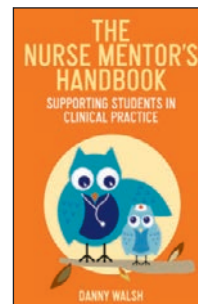
Clair Merriman and Liz Westcott
Both at Oxford Brookes University, UK

OSCEs or practical examinations are intended to challenge you both personally and professionally and this book is designed to be the ultimate companion to help you fly through OSCEs with ease.

Paperback £14.99
2010 200pp

ISBN: 978-0-335-23734-0
eBook: 978-0-335-24072-2
CourseSmart

BESTSELLER



The Nurse Mentor's Handbook Supporting Students in Clinical Practice

Danny Walsh
University of Nottingham, UK

All nurses have a duty, via their professional code of conduct, to pass on their knowledge and this book is the ideal companion text for all new and trainee nurse

mentors. This book provides a unique guide to strategies and ideas to help devise and enhance learning opportunities for their students.

It answers questions such as:

- How can I create a good learning environment?
- How should I assess students in practice?
- How do I support failing students?
- What should I include in my mentor's portfolio?

Paperback £21.99
2010 240pp

ISBN: 978-0-335-23721-0
eBook: 978-0-335-24067-8
CourseSmart



Reflective Practice for Healthcare Professionals 3/e

Beverley Taylor
Retired from Southern Cross
University, Australia

"This detailed, practical guide to reflective practice has relevance to all healthcare practitioners. Taylor offers readers her REFLECT model to guide

them through the process of reflection ... Throughout she uses a wide variety of techniques to explain and illustrate what to expect and how to adapt and accommodate to different circumstances and preferences ... This book has such depth and detail and yet at the same time is practical and written in plain language. There is literally something for everyone"
Canadian Journal of Occupational Therapy, April 2011

Paperback £23.99
2010 240pp

ISBN: 978-0-335-23835-4
eBook: 978-0-335-23836-1
CourseSmart

NEW EDITION

A Beginner's Guide to Evidence-Based Practice in Health and Social Care 2/e

Helen Aveyard and Pam Sharp
Both at Oxford Brookes University, UK

Have you heard of evidence based practice but don't know what it means? Are you having trouble relating evidence to your practice?

This is the book for anyone who has ever wondered what evidence based practice is or how to relate it to practice. Fully updated in this brand new edition, this book is simple and easy to understand – and designed to help those new to the topic to apply the concept to their practice and learning with ease. This new edition features:

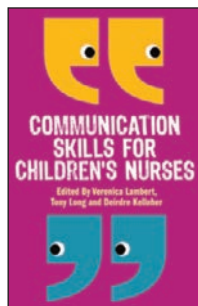
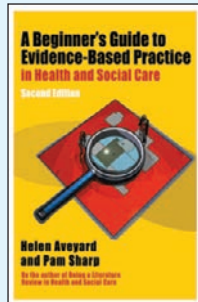
- Additional material on literature reviews and searching for literature
- Even more examples for health and social care practice
- Extra material on qualitative research and evidence based practice
- Expanded section on hierarchies of evidence a and how to use them

A Beginner's Guide to Evidence Based Practice in Health and Social Care is key reading for everyone involved in looking at and applying evidence in healthcare.

Contents: Introduction / What is evidence based practice? / Where did evidence based practice come from? / Using evidence in your decision making and to answer practical questions / What are the different types of research and how do they help us answer different questions? / How do I find relevant evidence to support my practice and learning? / How do I know if the evidence is convincing and useful? / How to implement evidence based practice / Glossary / References / Appendix: Useful websites

Paperback £21.99
April 2013 258pp

ISBN: 978-0-335-24672-4
eBook: 978-0-335-24673-1
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Communication Skills for Children's Nurses

Veronica Lambert, Tony Long and Deirdre Kelleher
Dublin City University, Ireland;
University of Salford, UK;
University College Dublin, Ireland

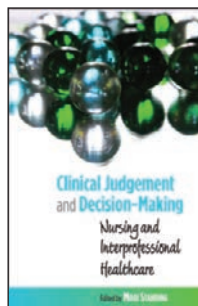
This guide will help children's nurses to communicate with confidence, sensitivity and effectiveness; to meet the

individual needs of children and their families. The book explores different aspects of communicating in this challenging environment using vignettes, examples, practice insights and tips.

The book emphasises the importance of listening to and respecting children's views and rights, in addition to respecting parent responsibility, rights and duty to act in the child's best interests. The authors show how a balance between protective exclusion and facilitated inclusion is core to communicating with children and families.

Paperback £19.99
2012 200pp

ISBN: 978-0-335-24286-3
eBook: 978-0-335-24288-7
[amazonkindle](#) [CourseSmart](#)



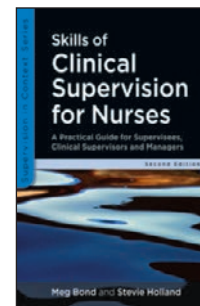
Clinical Judgement and Decision-Making in Nursing and Interprofessional Healthcare

Mooi Standing (Ed)
Canterbury Christchurch University, UK

Integrating the theory and practice of decision-making to guide and enhance practitioners' understanding and clinical expertise, the book presents relevant, contemporary theory and research that relates decision-making to professional identity, organization of healthcare, developing knowledge and skills and selecting and applying the most appropriate intervention in clinical practice.

Paperback £24.99
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ISBN: 978-0-335-23626-8
eBook: 978-0-335-24050-0
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Skills of Clinical Supervision for Nurses 2/e

Meg Bond and Stevie Holland
Both at GO Education consultancy, UK

This perennial bestseller provides a practical and accessible, skills-based text on how to implement and engage in clinical supervision. It provides clear frameworks

to guide learning, with real-life examples from across the range of nursing specialisms.

Paperback £23.99
2011 328pp

ISBN: 978-0-335-23815-6
eBook: 978-0-335-23816-3
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First Steps in Clinical Supervision: A Guide for Healthcare Professionals

Paul Cassidy
University of Nottingham, UK

This practical book is designed as a toolkit for anyone starting out as a clinical supervisor. The book focuses

on developing core skills of supervision, as well as your ability to reflect and improve on those skills.

Paperback £23.99
2010 216pp

ISBN: 978-0-335-23651-0
eBook: 978-0-335-23929-0
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Communication Skills for Adult Nurses

Sarah Kraszewski and Dr Abayomi McEwen (Eds)
Anglia Ruskin University; East of England Deanery, UK

"This book is excellent. It deals with every aspect of communication from the fundamental skills, through the use of technology, challenging situations, communication in teams, to the legal and ethical aspects of communication."
Conor Hamilton, Student Nurse, Queens University Belfast, UK

Paperback £19.99
2010 192pp

ISBN: 978-0-335-23748-7
eBook: 978-0-335-23999-3
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Learning Disability 2/e A Life Cycle Approach

Gordon Grant,
Margaret Flynn,
Malcolm Richardson and
Paul Ramcharan (Eds)
Sheffield Hallam University, UK;
Lancashire County Council's
Safeguarding Adults Board;
Sheffield Hallam University, UK;
RMIT University, Australia



Recognizing learning disability as a lifelong disability, this accessible book is structured around the life cycle. The second edition is refreshed and expanded to include seven new chapters, covering:

- Aetiology
- Breaking news and early intervention
- Transition to adulthood
- The sexual lives of women
- Employment
- Personalization
- People with hidden identities

Paperback £32.99
2010 536pp

ISBN: 978-0-335-23843-9
eBook: 978-0-335-23844-6
[amazonkindle](#) [CourseSmart](#)

Clinical Skills The Essence of Caring with DVD

Helen Iggulden,
Caroline MacDonald and
Karen Staniland (Eds)
Retired from University of Salford;
Robert Gordon University;
University of Salford, UK

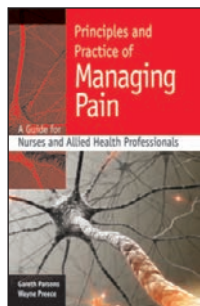
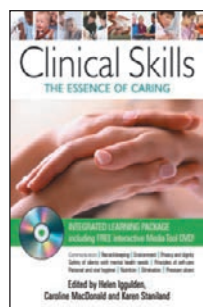
*"An excellent foundation
text for first year pre-
registration nurses. The*

*accompanying DVD encourages application of the
theory and helps consolidate learning."*

Janine Lee, Leeds Metropolitan University, UK

Based on the Essence of Care, this book and integrated DVD cover the core clinical skills curriculum. It includes a multitude of activity and case study boxes, a glossary, self-test questions and 25 patient scenarios that really bring the topics to life.

Paperback & DVD £30.99 ISBN: 978-0-335-22355-8
2009 236pp



Principles and Practice of Managing Pain A Guide for Nurses and Allied Health Professionals

Gareth Parsons and
Wayne Preece
Both at The University of
Glamorgan, UK

This practical introductory text provides an accessible guide to pain and how it affects patients and care giving. It considers:

- Pain types including acute, chronic and palliative
- Assessing pain
- Treatment and pharmacology of pain control
- Challenging situations and dilemmas
- Communicating with patients in pain
- Ethical and legal aspects of treating pain

Case studies, tools for decision making, insights on patient experiences and reflective exercises provide opportunities for you to reflect upon your own practice and to develop problem-solving and critical thinking skills.

Paperback £21.99
2010 216pp

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eBook: 978-0-335-24021-0
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Essential Calculation Skills for Nurses, Midwives and Healthcare Practitioners

Meriel Hutton
King's College London, UK

This handy book provides a guide to common numerical calculations found in healthcare practice and uses everyday examples to enable you to apply numerical principles correctly in your own practice. This user-friendly book:

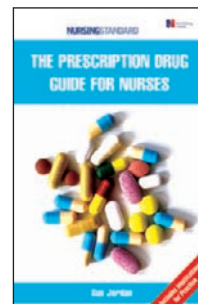
- Is full of authentic worked examples
- Features core clinical charts, prescription models, labels and diagrams

Meriel Hutton encourages you to find a method which suits you personally – with the emphasis always on patient safety.

Paperback £9.99
2008 163pp

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BESTSELLER



The Prescription Drug Guide for Nurses

Sue Jordan
University of Swansea, UK



This popular Nursing Standard prescription drug series is now available in book format. Organized by drug type and presented in an easy-to-use reference format, this

book outlines the implications for practice of 20 drug groups. Each drug group is presented in handy quick check format.

Paperback £16.99
2008 192pp

ISBN: 978-0-335-22547-7
eBook: 978-0-335-23550-6
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Palliative Care Nursing 2/e Principles and Evidence for Practice

Sheila Payne, Jane Seymour
and Christine Ingleton (Eds)
Lancaster University; University of
Nottingham; Sheffield Hallam
University, UK

*"An excellent book that I
would highly recommend to
anyone who works in*

*palliative care. The book is very informative and
reader friendly. It has an easy structure with each
chapter having an overview and key points ... A
great insight into health and illness utilizing
sociological and nursing theories. This book
definitely 'opened my eyes' to end of life care and
helped me to understand the bereavement process
and its implications on family members."*
*Isobel Weston, Student Nurse, University of
Nottingham, UK*

This textbook has been extensively revised to reflect new global developments in palliative care. It reviews current research and examines the evidence base for palliative care policy and practice. Over a third of the chapters are newly commissioned from leading international contributors.

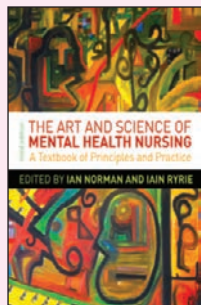
Paperback £32.99
2008 736pp

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eBook: 978-0-335-23646-6
[CourseSmart](#)

NEW EDITION

The Art and Science of Mental Health Nursing 3/e Principles and Practice

Ian Norman and
Iain Ryrie (Eds)
King's College London, UK;
Practising Nurse, UK



This comprehensive and bestselling nursing text has been fully and extensively

updated for this third edition, and offers students a complete guide to the art and science of mental health nursing. The book combines theory and practice to look in-depth at:

- Different 'types' of mental health problems
- Different therapeutic interventions
- The practical tools of nursing such as risk, assessment, problem solving
- Key themes such as ethics, law and professional issues

Fully updated by the editors and with a host of new contributing authors, this new edition has seven brand new chapters and a wealth of new features and material. The new edition includes:

- Expanded coverage of psychological interventions
- More emphasis on the skills and capabilities required by nurses in mental health nursing
- An updated evidence base including latest intervention evidence of what works in mental health nursing
- New chapters on: admission and discharge, group work, family and carers, solution focused approaches, counselling approaches motivational approaches, older adults with functional illness, CPD
- Additional case studies and practice examples to help students reflect as they learn
- Contributions from service users and carers

Contents: Part 1: Foundations / Part 2: Contexts / Part 3: Core procedures / Part 4: Interventions / Part 5: Client groups / Part 6: Future directions

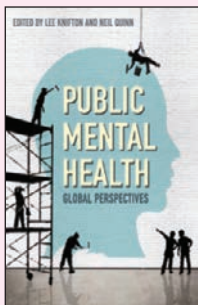
Paperback £32.99
April 2013 728pp

ISBN: 978-0-335-24561-1
eBook: 978-0-335-24562-8
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NEW

Public Mental Health Global Perspectives

Lee Knifton and
Neil Quinn (Eds)
Both at the University of
Strathclyde, UK



"The book provides a convincing account of the many ways in which our society could become more mentally healthy. It should be read by businessmen, teachers and politicians as much as by clinicians."

Professor Lord Layard

Mental health is a key public health priority, and this stimulating and comprehensive book offers an overview of the key issues in public mental health. Written by a team of leading international experts, the book summarizes the evidence base needed by both practitioners and students alike.

Each chapter includes:

- Mini toolkits that include tips for effective practice, reflection points and questions to consider
- Case studies exploring real world examples of public mental health in action
- Discussion and opinion encouraging readers to question and debate the issues at the core of public mental health policy

The book also includes an article written by Kate E. Pickett and Richard G. Wilkinson, authors of the best selling book *The Spirit Level*. It is an invaluable tool to give readers the confidence to develop effective mental health tools and programs that will improve public mental health.

Contents: Section 1: Promoting positive mental health / Section 2: Preventing mental health problems / Section 3: Quality of life for people with mental health problems / Section 4: Bringing it all together across the life-course

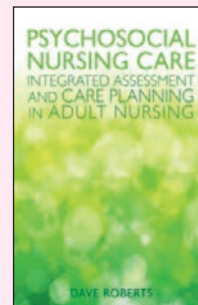
Paperback £24.99
March 2013 264pp

ISBN: 978-0-335-24489-8
eBook: 978-0-335-24490-4
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NEW

Psychosocial Nursing A Guide to Nursing the Whole Person

Dave Roberts
Oxford Brookes University, UK



Nurses care for the whole person but often lack guidance on how best to take care of a person's psychological needs when in a healthcare setting. This book explores simply and practically the importance

of giving good psychosocial nursing care, and helps readers develop the right skills to do this well. Each chapter includes examples based on real life situations, and extracts of fictional dialogue are used to show how nurses can communicate with patients in a therapeutic way – even during day-to-day care. The book includes:

- Chapters on working with patients experiencing anxiety, depression, and acute psychotic episodes as well as working with 'difficult' behaviours
- Handy Assessment Tools and Frameworks for nurses to use in their daily practice
- Patient voices throughout to bring the patient perspective to the fore

Contents: Section 1: Foundations of psychosocial care / Section 2: Mental health problems in general adult nursing

Paperback £24.99
May 2013 184pp

ISBN: 978-0-335-24414-0
eBook: 978-0-335-24415-7
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Nursing in Child and Adolescent Mental Health

Nisha Dogra and Sharon Leighton (Eds)
Both at the University of Leicester, UK

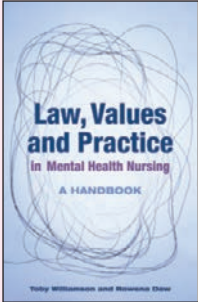
"Nurses have a key role to play within the Child and Adolescent Mental Health Team. This text will fill the void addressing legal and ethical issues while focusing upon clinical practice and the application of theoretical concepts."

Fiona Smith, Adviser in Children's and Young People's Nursing, Royal College of Nursing, UK

Paperback £22.99
2009 264pp

ISBN: 978-0-335-23463-9
eBook: 978-0-335-23938-2
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NEW



Law, Values and Practice in Mental Health Nursing A Handbook

Toby Williamson and Rowena Daw
Mental Health Foundation, UK; Mental Health Alliance, UK

Designed to explain the ins and outs of mental health law in an accessible and friendly way, the book looks at different stages of care delivery and a range of healthcare settings. The book includes guidance on admitting people to hospital, discharging people into the community, working with those in care homes, children and young people, the Human Rights Act, the Mental Capacity Act 2005, the deprivation of liberty safeguards and the revised Mental Health Act.

Contents: Part 1: The Mental Capacity Act 2005 (MCA) / The Human Rights Act and Equality Act / The Revised Mental Health Act 1983 (MHA) / The deprivation of liberty safeguards (DoLS) / Nursing ethics and value-based practice / Part 2: Working with people living in the community / Admitting people into hospital / Caring for and treating people in hospital / Discharging people from hospital / Working with people living in care homes / Working with children and young people

Paperback £23.99
April 2013 216pp

ISBN: 978-0-335-24501-7
eBook: 978-0-335-24502-4
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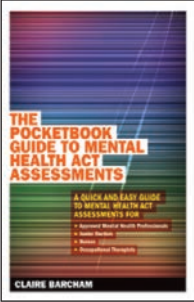
Practical Care Planning for Personalized Mental Health Care

Marjorie Lloyd (Ed)
Glyndwr University, UK

“This book provides readers with practical examples on how personalised mental healthcare can be achieved in practice. The authors bring to the text their own personal experiences which will benefit learners and enable them to see how theory can be applied in a practical way to resolve complex problems.”
Michael Nash, Lecturer, Trinity College Dublin, Ireland

Paperback £22.99
2012 232pp

ISBN: 978-0-335-24626-7
eBook: 978-0-335-24627-4
[amazonkindle](#) [CourseSmart](#)



The Pocketbook Guide to Mental Health Act Assessments

Claire Barcham
Camden and Islington Mental Health and Social Care Trust, UK

“This guide is an excellent resource ... It has a good balance between the legal context and practical / operational issues. I particularly like the checklists and examples from practice which can be used as an aide memoire ... This will be an invaluable reference book to keep in your assessment bag.”
Karen Lloyd, Training Consultant & AMHP, Oldham Council, UK

This pocketbook for AMHPs will help with the day-to-day aspects of their role including how to set up an assessment, how to undertake an assessment and how to make and implement informed decisions. The busy practitioner will find this guide invaluable when they need to quickly find information to complete an assessment.

Paperback £19.99
2012 224pp

ISBN: 978-0-335-24507-9
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Family Interventions in Mental Health

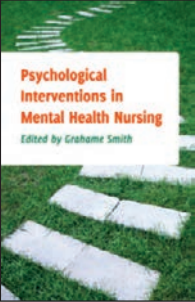
Neil Withnell and Neil Murphy
Both at the University of Salford, UK

Working with families and giving family interventions is a key aspect of promoting recovery in mental health nursing.

This text is ideal for mental health students and practitioners looking for a guide on delivering family interventions with a wide range of clients and in a broad range of settings. It includes case studies, examples and practical tools for the mental health professional to use in practice, and is the ideal guide for those new to family interventions.

Paperback £24.99
2012 208pp

ISBN: 978-0-335-24393-8
eBook: 978-0-335-24394-5
[amazonkindle](#) [CourseSmart](#)



Psychological Interventions in Mental Health Nursing

Grahame Smith (Ed)
Liverpool John Moores University, UK

Framed by the Nursing and Midwifery Council's (2010) standards for pre-registration nursing education and written by experts in the field, the book explains which interventions are most effective for each of the most common mental health disorders. It also shows you how these interventions work in practice and illustrates the skills required to use them in your own practice.

Paperback £22.99
2012 192pp

ISBN: 978-0-335-24416-4
eBook: 978-0-335-24417-1
[amazonkindle](#) [CourseSmart](#)

Communication Skills for Mental Health Nurses An Introduction

Jean Morrissey and Patrick Callaghan
Trinity College Dublin, Ireland; University of Nottingham, UK

This practical book provides a comprehensive guide to communication in mental health nursing, with an emphasis on demonstrating the use of different skills in various clinical settings.

Paperback £19.99
2011 216pp

ISBN: 978-0-335-23870-5
eBook: 978-0-335-23872-9
[amazonkindle](#) [CourseSmart](#)

Introduction to Mental Health Nursing

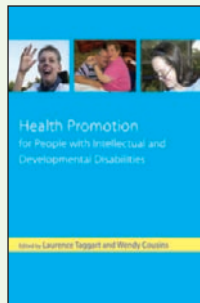
Nick Wrycraft (Ed)
Anglia Ruskin University, UK

This textbook provides a student focused introduction to the main issues and themes in mental health nursing. Scenarios and exercises are used to demonstrate integration of theory and practice. These can be easily linked to your placement experience and overall learning and development. Readers are encouraged to develop an analytical and investigative approach to their studies.

Paperback £24.99
2009 368pp

ISBN: 978-0-335-23358-8
eBook: 978-0-335-24080-7
[CourseSmart](#)

NEW



Health Promotion for People with Intellectual and Developmental Disabilities

Laurence Taggart and Wendy Cousins (Eds)
Both at the University of Ulster, UK

This book explores and explains the important and varied role of health promotion activities for people with intellectual and developmental disabilities. Written by an international board of experts in the area, the book covers a broad range of health promotion activities including:

- Health promotion in schools
- Family intervention
- Community health programmes
- Exercise and sport
- Health checks

Each chapter considers the physiological, psychological, environmental and cultural factors at play, and offers a 'how to' guide for a wide range of healthcare professionals working in the field of learning disability. Taking a lifespan approach the book considers a variety of challenges faced by those with learning disability, including physical illnesses such as epilepsy, obesity, cancer and sexual health issues, through to aspects of mental health and spirituality.

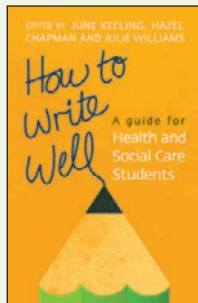
A highly topical book, this broad and far reaching text makes a valuable contribution to those trying to improve the health and lives of those living with a learning disability.

Contents: *Section 1: The health and health promotion needs of people with intellectual disabilities / Section 2: Health promotion evidence applied to practice / Section 3: Health promotion in context*

Paperback £28.99
August 2013 296pp

ISBN: 978-0-335-24694-6
eBook: 978-0-335-24695-3
[amazonkindle](#) [CourseSmart](#)

NEW



How to Write Well

A Guide for Health and Social Care Students

June Keeling,
Hazel Chapman and Julie Williams
All at the University of Chester, UK

Good writing skills are essential for all students, but many students struggle to master good

writing skills until later in their course. This book will help students doing health and social care subjects to better understand what good writing looks like, and how to do it themselves. The book shows students how to:

- Plan pieces of writing
- Execute good writing basics
- Edit and refine their work
- Write a brief

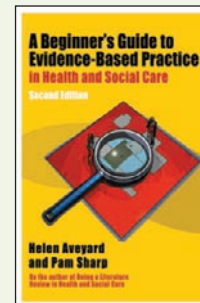
This essential guide includes multiple examples of good and bad writing to help students unpick the nuts and bolts of writing and writing skills. Taking an accessible approach, the authors include quotes and stories from real life students to help embolden students to tackle their writing fears – and become confident writers.

Contents: *Introduction / Preparation for writing / Basic writing skills / Advancing your writing skills / What is reflective writing? / Writing for practice / Presenting your writing in different formats / Student's stories / Conclusion*

Paperback £14.99
September 2013 224pp

ISBN: 978-0-335-24493-5
eBook: 978-0-335-24494-2
[amazonkindle](#) [CourseSmart](#)

NEW



A Beginner's Guide to Evidence-Based Practice in Health and Social Care 2/e

Helen Aveyard and Pam Sharp
Both at Oxford Brookes University, UK

Have you heard of evidence based practice but don't know what it means? Are you having trouble relating evidence to your practice?

This is the book for anyone who has ever wondered what evidence based practice is or how to relate it to practice. Fully updated in this brand new edition, this book is simple and easy to understand – and designed to help those new to the topic to apply the concept to their practice and learning with ease. This new edition features:

- Additional material on literature reviews and searching for literature
- Even more examples for health and social care practice
- Extra material on qualitative research and evidence based practice
- Expanded section on hierarchies of evidence and how to use them

A Beginner's Guide to Evidence Based Practice in Health and Social Care is key reading for everyone involved in looking at and applying evidence in healthcare.

Contents: *Introduction / What is evidence based practice? / Where did evidence based practice come from? / Using evidence in your decision making and to answer practical questions / What are the different types of research and how do they help us answer different questions? / How do I find relevant evidence to support my practice and learning? / How do I know if the evidence is convincing and useful? / How to implement evidence based practice / Glossary / References / Appendix: Useful websites*

Paperback £21.99
April 2013 258pp

ISBN: 978-0-335-24672-4
eBook: 978-0-335-24673-1
[amazonkindle](#) [CourseSmart](#)



A Guide to Practical Health Promotion

Mary Gottwald and Jane Goodman-Brown
Both at Oxford Brookes University, UK

"This book should become a key textbook of choice for a wide range of health care professionals and students."

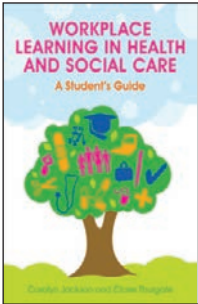
It encourages autonomous learning and helps develop critical analytical skills ... Each chapter follows a logical progression using key objectives which relate to a range of activities and up to date evidenced based sources of information. The range of depth and breadth of material is contemporary and as such should meet the academic, managerial and clinical background of the reader."

Helen Matthews, Senior Lecturer in Health and Community Care, University of West London, UK

This accessible book focuses on the practical activity of health promotion and shows nursing students how to actually 'do' health promotion in practice.

Each chapter uses classic case studies in HP, including lists, key points and other succinct tools to give readers guidance on 'doing' HP – and includes activities and specific tasks they can use in practice. The chapters explain the underlying theory in brief, and include the key evidence for HP activities – helping to build the readers confidence in their own health promotion skills.

Paperback £22.99
2012 224pp
ISBN: 978-0-335-24459-1
eBook: 978-0-335-24460-7
[amazonkindle](#) [CourseSmart](#)



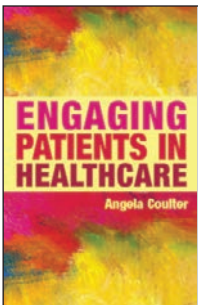
Workplace Learning in Health and Social Care
A Student's Guide

Carolyn Jackson and Claire Thurgate (Eds)
Both at Canterbury Christ Church University, UK

This practical book is an essential student guide to getting the most out of your workplace learning experiences in health and social care settings. The book is designed to help you understand how it links to your foundation degree, lifelong learning and your own individual personal development. The book:

- Provides practical strategies and exercises to strengthen your capacity to learn and reflect
- Shows you how to develop relationships with your employers and your multi-disciplinary team
- Explores how you can demonstrate evidence of learning in the workplace in your PDP and portfolio
- Includes quotes and tips from healthcare students, so you can learn from their experiences

Paperback £18.99
2011 160pp
ISBN: 978-0-335-23750-0
eBook: 978-0-335-23977-1
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Engaging Patients in Healthcare

Angela Coulter
Independent healthcare analyst and consultant, UK

This evidence-based guide provides the first comprehensive overview of patient engagement and participation in healthcare.

It has been written for all those who want to understand the various ways in which patient and public engagement can contribute to better health outcomes.

Paperback £24.99
2011 224pp
ISBN: 978-0-335-24271-9
eBook: 978-0-335-24272-6
[amazonkindle](#) [CourseSmart](#)



Social Aspects of Health, Illness and Healthcare

Mary Larkin
De Montfort University, UK

"This is an easy-to-read introductory text exploring the social aspects of health, illness and healthcare. Key concepts are introduced carefully and there is a helpful glossary of key terms. Activities and discussion points enable students to pace their learning and illustrative case studies bring the text to life. In short, this is a gentle yet comprehensive introduction which will no doubt become popular with lecturers and students alike."

Dr Sarah Earle, Associate Dean Research, The Open University, UK

This introductory core textbook is the ideal companion text for students studying the social aspects of health and illness, whether it is as part of a health studies degree, nursing or other professional qualification related to health, social care, youth and community work and social work.

This engaging book is full of case studies, primary sources and activities for study, all of which will help you get to grips with the core concepts and themes in the study of health, illness and healthcare.

Paperback £23.99
2011 280pp
ISBN: 978-0-335-23662-6
eBook: 978-0-335-23987-0
[amazonkindle](#) [CourseSmart](#)

Key Debates in Health Care

Gary Taylor and Helen Hawley
Sheffield Hallam University; Rotherham PCT, UK

"This is an accessible text that will be a useful source for lecturers and students in the field of health studies. The material is coherently organized into three main themes: the politics of provision; setting priorities; and patients and professionals. I was particularly impressed with the way in which the authors draw on theoretical insights and experiences of different health care systems in their analysis."

Professor Rob Baggott, Director of the Health Policy Research Unit, De Montfort University, UK

Paperback £21.99
2010 240pp
ISBN: 978-0-335-22394-7
eBook: 978-0-335-24054-8


Case Book Series

This new series of case books is written for nursing and other allied health profession students. They are designed to help students link theory and practice and provide an engaging and focused way to learn.

Perioperative Practice Case Book

Paula Strong and Suzanne J Hughes (Eds)
Both at Cardiff University, UK

This book comprises numerous case studies in the field of perioperative practice and is designed to help students revise and prepare for exams.

Each case study includes:

- Full case study background including patient presentation, histories and clinical information
- Questions relating to physiology, pathophysiology, clinical procedures and other aspects of perioperative practice
- Fully explained answers that include clinical charts, diagrams and figures and good clinical overviews

In addition to case studies the authors provide several chapters offering an overview of assessment within perioperative practice. These case studies are ideal for exam preparation, and to help students link theory to practice and apply it to real life scenarios.

Contents: Principles of assessment / Handover / Principles of patient assessment / Procedure assessment / Anaesthetic assessment / Resource assessment / Cases: General surgery / Gynaecology / Trauma / Orthopaedic / Spinal / Neurological / Cardiac / Thoracic / Urology / Breast / Vascular / ENT / Maxillofacial / Paediatric / Oncology / Obstetric / Bariatric surgery

Paperback £21.99
December 2013 232pp

ISBN: 978-0-335-24503-1
eBook: 978-0-335-24504-8
[amazonkindle](#) [CourseSmart](#)

NEW

Learning Disabilities in Health Care Settings Case Book

Bob Hallawell

Learning Disability Practice and British Journal of Nursing, UK

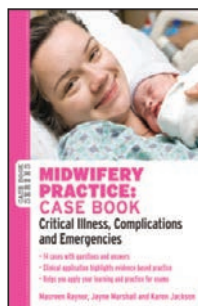
This book for learning disability nurses comprises 22 different case studies relating to learning disabilities in health care. The case studies give an opportunity to learn about different aspects of good quality care giving in the learning disability field, plus a chance for students and practitioners to test their understanding. Each case features questions and answers on a range of topics from physiology to professional skills, ethical dimensions to communication skills – all designed to help students develop their care giving skills and prepare for exams or essay based tests. This innovative text covers a broad range of topics and scenarios, each one based on real life practice.

Contents: Section 1: Understanding learning disabilities – Origins and contemporary practice
Section 2: Childhood and adolescence / Section 3: Adulthood

Paperback £19.99
December 2013 240pp

ISBN: 978-0-335-24307-5
eBook: 978-0-335-24308-2
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NEW



Midwifery Practice Critical Illness, Complications and Emergencies Case Book

Maureen Raynor, Jayne Marshall and Karen Jackson
All at the University of Nottingham, UK

This case book for student midwives is essential reading and contains over 14 common pregnancy and childbirth emergency scenarios. Each case explores and explains the pathology, pharmacology plus key care principles using test questions and answers to help assess learning.

Paperback £24.99
2012 280pp

ISBN: 978-0-335-24273-3
eBook: 978-0-335-24274-0
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Mental Health Nursing Case Book

Nick Wrycraft (Ed)
Anglia Ruskin University, UK

This case book includes a wide range of mental health diagnoses from common problems such as anxiety or depression through to severe and enduring conditions such as schizophrenia. The cases

are organized into sections by life stage from childhood through to old age.

Paperback £19.99
2012 272pp

ISBN: 978-0-335-24295-5
eBook: 978-0-335-24296-2
[amazonkindle](#) [CourseSmart](#)



Paramedics From Street to Emergency Department Case Book

Sarah Fellows and Bob Fellows
Imperial College; University of Hertfordshire, UK

This accessible book is designed to help both practising and student paramedics prepare to deal with 25 of the most

commonly seen pre-hospital care scenarios, as well as to revise for practical exams.

Paperback £21.99
2012 176pp

ISBN: 978-0-335-24267-2
eBook: 978-0-335-24268-9
[amazonkindle](#) [CourseSmart](#)

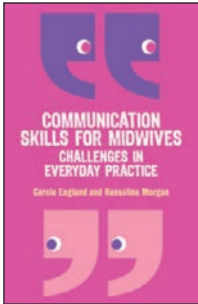
Nursing the Acutely Ill Adult Case Book

Karen Page and Aiden McKinney
Both at Queen's University Belfast, UK

Part of a case book series, this accessible book contains 17 in-depth case studies relating to care of the acutely ill adult. The cases combine pathophysiology, pharmacology and nursing care in realistic clinical settings, providing an engaging resource for nursing students taking acute care modules.

Paperback £21.99
2012 200pp

ISBN: 978-0-335-24309-9
eBook: 978-0-335-24310-5
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Communication Skills for Midwives
Challenges in Every Day Practice

Carole England and
Ransolina Morgan
Both at the University of
Nottingham, UK

“Communication Skills for Midwives is a unique book that focuses not only on fundamental communication

issues, but goes much further by including the many difficult and tricky issues experienced within contemporary midwifery practice. This much needed text provides detailed and comprehensive information which is reinforced by illustrations, vignettes and activities that engage the reader from the beginning. This is an excellent resource for students, practitioners and educators.”

Nicky Clark, Lead Midwife for Education, University of Hull, UK

“This book covers many poignant examples of difficult and challenging communication that midwives face in everyday practice ... It covers both every day aspects of care such as facilitating choice and less common experiences like responding to domestic violence ... This book is unique and would be good bedtime reading for any midwife!”

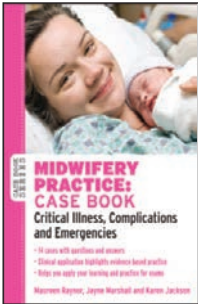
Tandy Deane-Grey, Senior Midwifery Lecturer, University of Hertfordshire, UK

This new text considers the challenges midwives face when communicating with women during pregnancy, labour and in the puerperium. Each chapter looks at a key challenge, and provides guidance on how best to work with women and their families.

The book includes case vignettes, examples, tools and techniques and will provide you with the evidence base needed to communicate effectively in a range of challenging situations.

Paperback £19.99
2012 152pp

ISBN: 978-0-335-24399-0
eBook: 978-0-335-24400-3
[amazonkindle](#) [CourseSmart](#)



Midwifery Practice
Critical Illness, Complications and Emergencies Case Book

Maureen Raynor,
Jayne Marshall and
Karen Jackson
All at the University of
Nottingham, UK

“The authors are to be commended as this is the first book of its kind and is well overdue ... The content is excellent, well referenced and covers all of the important issues ... The layout makes the book easy to read and the inclusion of pre-reading, self-assessment of knowledge and case studies engages the reader and stimulates further study into the pathophysiology and management of obstetric emergencies. I particularly liked the chapter on sepsis.”

Professor Christine Kettle, University Hospital of North Staffordshire & Staffordshire University, UK

This case book for student midwives is essential reading and contains over 14 common pregnancy and childbirth emergency scenarios. Each case explores and explains the pathology, pharmacology plus key care principles using test questions and answers to help assess learning.

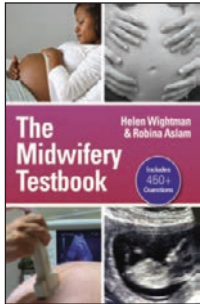
The practical cases will assist in linking theory to practice and their grounding in reality will really help bring midwifery topics to life.

The book also:

- Covers the principles, pathology and skills involved in a range of birthing scenarios
- Acts as a useful aide memoire when simulating managing care procedures
- Demonstrates the importance of interprofessional team working in problem-solving
- Uses tables, diagrams and textboxes throughout

Paperback £24.99
2012 280pp

ISBN: 978-0-335-24273-3
eBook: 978-0-335-24274-0
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The Midwifery Testbook

Helen Wightman and
Robina Aslam
Both at the University of
Nottingham, UK

“This will be a great revision tool ... Each type of question is used to enhance the development of the student by self assessment of their knowledge and

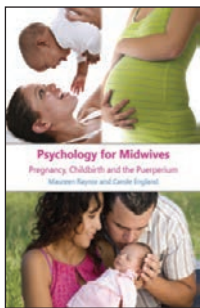
understanding of the relevant anatomy and physiology and the application to practice ... I will strongly recommend this excellent text to all student midwives.”

Nan Morse, Professional Head of Midwifery Education, University of Glamorgan, UK

This testbook includes over 450 questions relating to your midwifery course, multiple choice, true or false, short answer and diagram questions. It also includes pharmacology tests and calculation skill questions - making this an all round resource to help you excel in midwifery exams!

Paperback £19.99
2012 304pp

ISBN: 978-0-335-24479-9
eBook: 978-0-335-24480-5
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Psychology for Midwives
Pregnancy, Childbirth and Puerperium

Maureen Raynor and
Carole England
Both at the University of
Nottingham, UK

“This is an excellent aid in grasping the key concepts of psychology in a focused way, clearly demonstrating how the key concepts can be used within modern day midwifery practice settings.”

Kimberley Skinner, Student Midwife, Anglia Ruskin University, UK

This evidence-based book provides simple explanations for why psychological care matters in midwifery practice and uses different theoretical perspectives of psychology to illustrate how it fundamentally contributes to good midwifery practice.

Paperback £25.99
2010 208pp

ISBN: 978-0-335-23433-2
eBook: 978-0-335-24034-0
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BESTSELLER

A Sociology of Mental Health and Illness 4/e

Anne Rogers and David Pilgrim
University of Manchester;
University of Central Lancashire, UK

A former BMA Medical Book of the Year award winner

This book provides a sociological analysis of major areas of mental health and illness and helps students to

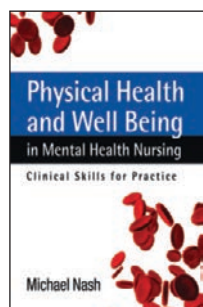
develop a critical approach to the subject.

This new edition is fully updated, taking into consideration changes in the areas of sociology, social psychiatry and policy analysis and changes to policy and therapeutic law.

A new chapter entitled 'Public mental health and the pursuit of happiness', reflects the recent focus on the creation of mentally healthy societies.

Paperback £27.99
2010 344pp

ISBN: 978-0-335-23665-7
eBook: 978-0-335-24037-1
CourseSmart*



Physical Health and Well-Being in Mental Health Nursing Clinical Skills for Practice

Michael Nash
Trinity College Dublin, Ireland

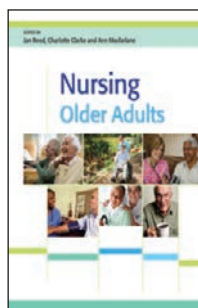
"This a well-researched and practical guide to understanding the physical

health needs of people diagnosed with mental illness. The book's major strength is distilling the practical steps that nurses can take to improve their practice in this area. It is written in an engaging style, and covers topics central to improving mental health service users' physical health and well being."

Dr Patrick Callaghan, Professor of Mental Health Nursing, University of Nottingham, UK

Paperback £24.99
2010 288pp

ISBN: 978-0-335-23399-1
eBook: 978-0-335-24013-5
CourseSmart*



Nursing Older Adults

Jan Reed, Charlotte Clarke and Anne MacFarlane (Eds)
University of Northumbria, UK;
University of Northumbria, UK;
Retired

"At a time when the number of older people in our society is growing and, when their care is often unfavourable under the spotlight, this book

will provide an invaluable resource for nurses."

Dame Christine Beasley, DBE, Chief Nursing Officer for England

"Never was a book like this more urgently needed. Its combination of authority and experience makes it especially valuable ... Those who nurse older people will find much sound help within these pages."

Broadcaster and writer Dame Joan Bakewell

"A great book: giving a comprehensive insight in the fundamentals of working with older people and key issues in nursing older people... The voice of older people is vividly written in many examples and scenarios given. I recommend this book to nurses, care staff, all who are in the education and qualification sector and other stakeholders in elder care."

Professor Dr. Barbara Klein, Fachhochschule Frankfurt am Main - University of Applied Sciences, Germany

This timely textbook aims to provide adult nurses with the principles and practice insights needed to deliver exceptional care in partnership with older adults. Written by a world renowned author team and includes contributions by older people, ensuring their needs and concerns about nursing care are reflected across the book.

Nursing Older Adults will help nurses to better appreciate the experiences and strengths of older people. The book emphasises the importance of undertaking a collaborative approach when shaping the care that older people receive in a variety of healthcare settings.

Paperback £28.99
2011 320pp

ISBN: 978-0-335-24084-5
eBook: 978-0-335-24085-2
amazonkindle CourseSmart*

BESTSELLER

Excellence in Dementia Care Research into Practice

Murna Downs and Barbara Bowers (Eds)
University of Bradford, UK;
University of Wisconsin-Madison, USA

"Written by leading theorists from a range of countries, this comprehensive text is a unique achievement. Despite there being 46 contributors, there is a consistent voice

addressing current thinking in dementia care, with good cross referencing. Expertise of researchers, practitioners and academic tutors is brought together in a stimulating, informative and sometimes provocative read."
Nursing Standard

In addressing the many complex issues related to offering support to people with dementia and those who care for them, this timely textbook is unique in emphasizing strategies for creating sustainable change in practice. The book includes examples from a range of countries, drawn from research, practice wisdom and, most importantly, from the experience of people with dementia and their families.

Paperback £29.99
2008 640pp

ISBN: 978-0-335-22375-6
eBook: 978-0-335-23675-6
amazonkindle CourseSmart*

Communication and the Care of People with Dementia

John Killick and Kate Allan
Dementia Positive, UK

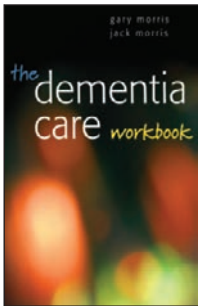
"The book is much more than an exhortation to carers about how they should communicate. It challenges them to understand themselves and shows how they might use themselves to engage with people with dementia."

Faith Gibson, Emeritus Professor of Social Work

This book argues that communication is at the heart of all approaches to dementia care, and is an in-depth exploration of ways of establishing and developing communication with people with dementia. It examines both the nature of dementia as a condition and the subjective experience of those affected.

Paperback £26.99
2001 330pp

ISBN: 978-0-335-20774-9



The Dementia Care Workbook
Gary Morris and Jack Morris
The University of Leeds; Retired, UK

This workbook builds upon the person-centred approach to dementia care, and gives students, practitioners and carers a new way of looking at dementia and the people who live with it. The authors reflect upon the reality of working within dementia care and the importance of working positively with others to achieve the best care possible.

The workbook is full of exercises and activities to try, all designed to help you engage and connect with the person with dementia, empowering both them and their families / carers.

Throughout the workbook, vignettes featuring two fictional characters living with dementia, provide examples of good and realistic practice and encourage you to examine your own practice and explore ways in which the care you give can be enhanced.

Paperback £22.99 ISBN: 978-0-335-23431-8
2010 192pp eBook: 978-0-335-24009-8



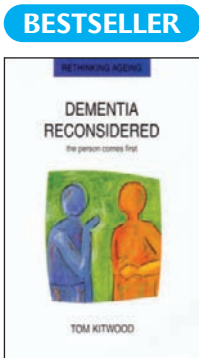
Tom Kitwood on Dementia
A Reader and Critical Commentary

Clive Baldwin and Andrea Capstick
Both at the University of Bradford, UK

“The book will be valuable for undergraduate and postgraduate students, researchers and lecturers involved in the field of dementia care and the healthcare sciences. Furthermore, it provides a useful resource for clinicians who wish to explore their understanding of ‘personhood’, person-centred care and the nature of Kitwood’s critical appraisal of how ‘care’ has been constructed and delivered.”
Ageing and Society

Tom Kitwood was one of the most influential writers on dementia of the last 20 years. This reader brings together 20 original publications by Kitwood which span the entire period of his writing on dementia, and the different audiences for whom he wrote.

Paperback £22.99 ISBN: 978-0-335-22271-1
2007 384pp



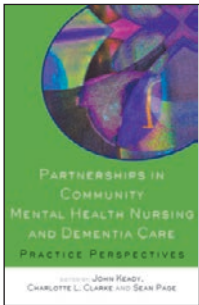
Dementia Reconsidered
The Person Comes First
Tom Kitwood
University of Huddersfield, UK

Tom Kitwood broke new ground in this classic book. Many of the older ideas about dementia are subjected to critical scrutiny and reappraisal, drawing on research evidence, logical analysis and the author’s own experience.

Each chapter provides a definitive statement on a major topic related to dementia, for example: the nature of ‘organic mental impairment’, the experience of dementia, the agenda for care practice, and the transformation of the culture of care.

The book clearly demonstrates the possibility of a better life for people who have dementia, and comes to a cautiously optimistic conclusion.

Paperback £24.99 ISBN: 978-0-335-19855-9
1997 192pp



Partnerships in Community Mental Health Nursing and Dementia Care Practice Perspectives

John Keady, Charlotte L. Clarke and Sean Page (Eds)
University of Manchester; Northumbria University; Manchester Mental Health NHS and Social Care Trust, UK

“How useful is this book? I have referred to it often, and found myself quoting information and models of care from it. I lent it to a colleague to prepare a presentation on ‘challenging behaviour’ to our local carers group and he thought it was an excellent resource. It is key reading for any mental health professional with an interest in improving the quality of life of people with dementia. I would recommend that all community teams have a copy.”
Dementia

Paperback £25.99 ISBN: 978-0-335-21581-2
2007 312pp eBook: 978-0-335-22991-8



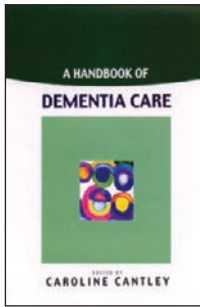


Mental Health and Well-Being in Later Life
Mima Cattam
University of Northumbria, UK

Taking a holistic approach to mental health and mental health promotion, the book explores the debates around what is meant by mental health and mental illness and the wider social determinants of mental health.

A range of examples from the UK and other countries, along with insights gained from older people’s own perspectives, are used to emphasize the evidence base for effective interventions to promote mental health. Case studies, vignettes and quotes demonstrate how social theory and principles of health promotion can be effectively applied to improve practice.

Paperback £23.99 ISBN: 978-0-335-22892-8
2009 184pp eBook: 978-0-335-23930-6



A Handbook of Dementia Care
Caroline Cantley
University of Northumbria UK

This handbook provides a unique, multidisciplinary and critical guide to what we know about dementia and dementia care. It also demonstrates the value of a wide range of perspectives in understanding dementia care, reviews the

latest thinking about good practice, and examines key ethical issues. It explores the way organizations, policy and research shape dementia care.

The book is written by leading academics, practitioners and managers involved in the development of dementia care.

Paperback £29.99 ISBN: 978-0-335-20383-3
2001 268pp eBook: 978-0-335-23104-1



Understanding Public Health

Series Editors:

Nicki Thorogood and Ros Plowman

This innovative series of books is published by Open University Press in collaboration with the London School of Hygiene and Tropical Medicine. It provides self-directed learning covering the major issues in public health affecting low, middle and high income countries.

Health Promotion Theory 2/e

NEW EDITION

Maggie Davies, Wendy Macdowall and Liza Cragg (Eds)
All at LSHTM, UK

Part of the Understanding Public Health series, this fully updated new edition aims to help students and professionals develop understanding of the core health promotion theories. In doing so it helps readers use these theories to underpin their practice. The new edition has been comprehensively updated by a new author and now includes more in depth chapters that:

- Take an in depth look at key issues including determinants of health
- Are completely up to date with current health promotion theory and issues
- Focus more on the underpinning theory of health promotion activities

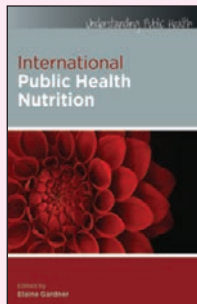
Contents: *Section 1: History and concepts / History of health promotion / Social construction of health and health promotion / What drives health promotion? / Ethics / Section 2: Using theory to inform health promotion practice / Using theory to inform health promotion and guide change at the individual level / Theory guiding change at the community level / The determinants of health / Theorising inequalities in health / Health communication / Rose hypothesis*

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NEW

International Public Health Nutrition

Elaine Gardner (Ed)
LSHTM, UK



Food and nutrition are fundamental to survival and play a major part in the Public Health arena. Study in public health nutrition is becoming increasingly popular and important, both in low and high resource countries as well as those in transition.

This book is being developed alongside a new module that will form part of the distance learning MSc Public Health programme at the London School of Hygiene and Tropical Medicine and will be part of the Understanding Public Health Series. By using examples of recent public health interventions from a variety of settings, this key text will help readers to fully understand the role of nutrition in public health.

Contents: *Part 1: Introduction to public health nutrition / Part 2: Planning and reviewing nutrition interventions / Part 3: Nutrition and disease in public health / Part 4: Public health nutrition through the life cycle*

Paperback £24.99 ISBN: 978-0-335-24749-3
October 2013 248pp eBook: 978-0-335-24750-9
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Principles of Social Research 2/e

NEW EDITION

Mary Durand and Tracey Chantler (Eds)
Both at LSHTM, UK

Fully updated in this second edition, this book introduces students to basic principles in social research. The book uses examples from a range of settings to illustrate how qualitative and quantitative methods from the disciplines of sociology, psychology, history and anthropology have been used to understand health related behaviour. Praised for its clarity and breadth, this book is being thoroughly updated with:

- Extended further reading
- More in-depth chapters reflecting the most current topics in the field of social research
- Extended further reading
- Expanded material on the use of secondary sources
- More coverage on the usage of studies within larger public health programmes, including mixed methods and integration of data
- Increased number of international examples and updated case studies

Contents: *Introduction / Research design / Data generation and collection / Analysis and interpretation*

Paperback £29.99 ISBN: 978-0-335-26330-1
December 2013 216pp eBook: 978-0-335-26331-8
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Conflict and Health

Natasha Howard, Egbert Sondorp and Anne Marie Ter Veen (Eds)
All at LSHTM, UK

This introductory text explores the interventions used in humanitarian crises, and concludes by considering post-conflict resolution issues.

Paperback £24.99 ISBN: 978-0-335-24379-2
2012 224pp eBook: 978-0-335-24380-8
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Financial Management in Health Services

Reinhold Gruen and Anne Howarth
LSHTM; Freelance Consultant, UK

Financial management is a highly effective means of implementing key policies in health services. This book shows how healthcare policies and programmes to promote the health of the public can be supported through financial management techniques.

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Environment, Health and Sustainable Development 2/e

Sari Kovats and Emma Hutchinson
Both at LSHTM, UK

This book examines the underlying concepts, the history of environmental health, and the key factors that affect public health including air pollution, water contamination, industrial hazards and agricultural hazards. It has been fully revised to discuss recent international environmental conventions and legislation in fast-moving world of environmental health.

UK and global issues are covered such as urbanisation and the impact of transport on air pollution, and the impact of globalisation on high and low income countries.

Contents: Introduction / Environment and health / Changing pressures / Chemicals in environment / Water and sanitation / Housing and indoor environment / Outdoor air pollution and transport / Waste / Built environment / Disasters / Energy use / Global climate system / Ecosystem services / Action at global and local levels

Paperback £24.99
October 2013 264pp
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eBook: 978-0-335-24538-3
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Public Health in History
Virginia Berridge, Martin Gorsky and Alex Mold (Eds)
Both at LSHTM, UK
"This clear and informative volume, packed with rich sources and illustrations, will be a must for students and scholars embarking on a study of public health. Covering a range of geographical areas and a wide array of topics, it also succeeds in being challenging and thought-provoking, urging its readers to engage with the ways in which historical research can shape our understanding of current health issues."
Professor Hilary Marland, Centre for the History of Medicine, University of Warwick, UK

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BESTSELLER

Issues in Public Health 2/e



Fiona Sim and Martin McKee (Eds)
Both at LSHTM, UK

By looking at the foundations of public health, its historical evolution, the themes that underpin public health and the increasing importance of globalization, this book provides thorough answers to these important questions. The new edition has been

updated to identify good modern public health practice, evolving from evidence.

Paperback £24.99
2011 296pp
ISBN: 978-0-335-24422-5
eBook: 978-0-335-24423-2
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BESTSELLER

Introduction to Health Economics 2/e



Lorna Guinness and Virginia Wiseman (Eds)
Both at LSHTM, UK

This practical text offers the ideal introduction to the economic techniques used in public health and is accessible enough for those who have no or limited knowledge of economics.

Paperback £24.99
2011 288pp
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Health Promotion Practice

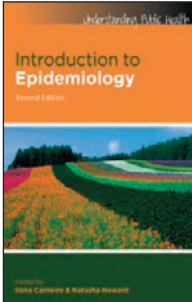
Wendy Macdowall, Chis Bonnell and Maggie Davies
LSHTM; LSHTM; National Institute for Health and Clinical Excellence, UK

This book considers the key steps in the practical application of health promotion. It starts by showing how it is first necessary to determine the needs of a population and to review the scientific evidence to justify intervening.

Paperback £24.99
2006 256pp
ISBN: 978-0-335-21840-0
eBook: 978-0-335-22998-7
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BESTSELLER

Introduction to Epidemiology 2/e



Ilona Carneiro and Natasha Howard
Department of Infectious and Tropical Diseases, Madrid, Spain; LSHTM, UK

This popular book introduces the principles, methods and application of epidemiology for improving health and survival. The book assists readers in applying basic epidemiological methods to

measure health outcomes, identifying risk factors for a negative outcome, and evaluating health interventions and health services.

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Sexual Health A Public Health Perspective



Kaye Wellings, Martine Collumbien and Kirstin Mitchell
All at LSHTM, UK

This key textbook provides a firm grounding in theoretical and practical aspects of the study of sexual health for both undergraduates and post-graduates. It includes global examples, case studies and the popular pedagogical features found in these series titles.

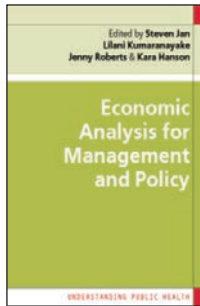
Paperback £24.99
2012 256pp
ISBN: 978-0-335-24481-2
eBook: 978-0-335-24482-9
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Managing Health Services

Nick Goodwin, Reinhold Gruen and Valerie Iles
All at LSHTM, UK

This book provides an understanding of the concepts of management, managerial leadership and governance within healthcare systems.

Paperback £24.99
2005 248pp
ISBN: 978-0-335-21852-3
eBook: 978-0-335-22516-3
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Economic Analysis for Management and Policy

Stephen Jan,
Lilani Kumaranayake,
Jenny Roberts, Kara Hanson
and Kate Archibald (Eds)
All at LSHTM, UK

As issues of resource scarcity become more explicitly acknowledged in the health

sector, public health practitioners are recognizing that economics can form a vital part of their professional toolkit. This book discusses theoretical perspectives in health economics by developing an appreciation of how economic concepts and techniques can be applied in policy making and management in the health sector.

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Global Change and Health

Kelley Lee and Jeff Collin
Both at LSHTM, UK

To effectively address health concerns exceeds the capacity of individual countries acting alone through domestic institutions. The issues covered include:

- Food, tobacco and pharmaceuticals
- Emerging infectious diseases
- Climate change,
- Economy and trade
- Security and governance

Paperback £24.99
2005 232pp

ISBN: 978-0-335-21848-6
eBook: 978-0-335-22615-3



Economic Evaluation

Julia Fox-Rushby and John Cairns
Brunel University; LSHTM, UK

There are so many ways in which health might be improved today and, as technology improves, the opportunities will increase. This book examines how to undertake economic evaluation of health care interventions in low, middle and high income countries.

Paperback £24.99
2005 264pp

ISBN: 978-0-335-21847-9
eBook: 978-0-335-22506-4



Understanding Health Services

Reinhold Gruen and Nick Black
Both at LSHTM, UK

This book provides you with a series of conceptual frameworks which help to unravel the apparent complexity that confronts the inexperienced observer. It also shows the necessity to consider healthcare at three key levels

Paperback £24.99
2005 256pp

ISBN: 978-0-335-21838-7
eBook: 978-0-335-22428-9



Analytical Models for Decision-Making

Colin Sanderson and Reinhold Gruen
Both at LSHTM, UK

This book describes the quantitative and qualitative methods that can help decision-makers to structure and clarify difficult problems and to explore the implications of pursuing different options.

Paperback & CD £24.99
2006 224pp

ISBN: 978-0-335-21845-5
eBook: 978-0-335-22773-0



Controlling Communicable Disease

Norman Noah
LSHTM UK

This book is about controlling diseases and conditions, a task that is impossible without surveillance, knowledge of basic microbiology and multi-disciplinary public health teams.

Paperback £24.99
2006 256pp

ISBN: 978-0-335-21844-8
eBook: 978-0-335-22667-2



Environmental Health Policy

David Ball
LSHTM, UK

Environmental health policy occupies a prominent position on both local and global agendas as old and new challenges confront the human race. This book provides a multidisciplinary window onto environmental policy and its formulation.

Paperback £24.99
2006 296pp

ISBN: 978-0-335-21843-1
eBook: 978-0-335-22949-9



BESTSELLER



Making Health Policy 2/e

Kent Buse, Nick Mays and
Gill Walt
UNAIDS; Both at LSHTM, UK

This edition includes the latest policy developments from around the globe, updated discussions to reflect the latest health policy changes, updated data and policy references and updated and new examples of health policy.

Paperback £24.99
2012 288pp

ISBN: 978-0-335-24634-2
eBook: 978-0-335-24635-9



Medical Anthropology

Robert Pool and Wenzel Geissler
Both at LSHTM, UK

This book introduces the basic concepts, approaches and theories used, and shows how these contribute to understanding complex health related behaviour. Public health policies and interventions are more likely to be effective if the beliefs and behaviour of people are understood and taken into account.

Paperback £24.99
2005 184pp

ISBN: 978-0-335-21850-9
eBook: 978-0-335-22749-5



Health Care Evaluation

Sarah Smith, Don Sinclair, Rosalind Raine and
Barnaby Reeves
LSHTM; Slough PCT; LSHTM; Formerly LSHTM, UK

Paperback £24.99
2005 216pp

ISBN: 978-0-335-21849-3
eBook: 978-0-335-22794-5



Environmental Epidemiology

Paul Wilkinson
LSHTM, UK

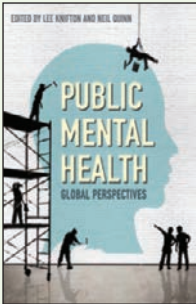
This book describes the methods available for public health practitioners to enable investigations to be carried out and how findings should be interpreted to ensure that the most appropriate policies are adopted.

Paperback £24.99
2006 224pp

ISBN: 978-0-335-21842-4
eBook: 978-0-335-22841-6



NEW



Public Mental Health
Global Perspectives

Lee Knifton and
Neil Quinn (Eds)
University of Strathclyde, UK

"The book provides a convincing account of the many ways in which our society could become more mentally healthy. It should be read by businessmen, teachers and politicians as much

as by clinicians."
Professor Lord Layard

Mental health is a key public health priority, and this stimulating and comprehensive book offers an overview of the key issues in public mental health.

Written by a team of leading international experts, the book summarizes the evidence base needed by both practitioners and students alike.

Each chapter includes:

- Mini toolkits that include tips for effective practice, reflection points and questions to consider
- Case studies exploring real world examples of public mental health in action
- Discussion and opinion encouraging readers to question and debate the issues at the core of public mental health policy

The book also includes an article written by Kate E. Pickett and Richard G. Wilkinson, authors of the best selling book *The Spirit Level*.

It is an invaluable tool to give readers the confidence to develop effective mental health tools and programs that will improve public mental health.

Contents: *Section 1: Promoting positive mental health / Section 2: Preventing mental health problems / Section 3: Quality of life for people with mental health problems / Section 4 : Bringing it all together across the life-course*

Paperback £24.99
March 2013 264pp

ISBN: 978-0-335-24489-8
eBook: 978-0-335-24490-4
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The Future Public Health

Phil Hanlon, Sandra Carlisle,
Margaret Hannah and
Andrew Lyon
University of Glasgow; University
of Glasgow; NHS Fife; International
Futures Forum, UK

This innovative text bridges the gap between current public health values and skills and those required to tackle

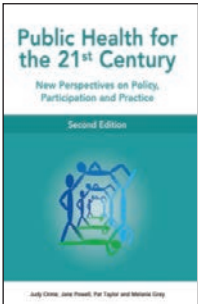
future challenges. The authors introduce the key models and theories of public health, as well as the factors that have shaped its history and development.

The Future Public Health is informed by a six year research project, commissioned by the Scottish Government, to trace the development of our current situation and look for solutions to the challenges facing public health.

Visit the AfterNow website www.afternow.co.uk to access an array of resources.

Paperback £24.99
2012 208pp

ISBN: 978-0-335-24355-6
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Public Health for the 21st Century 2/e

Judy Orme, Jane Powell,
Pat Taylor and Melanie Grey
All at the University of the West of
England, UK

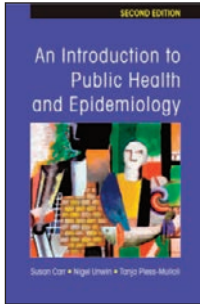
This bestselling book has been substantially updated to take account of changing policy and practice. The introduction gives a

comprehensive overview of the field of public health.

Throughout this book, the authors analyze and reflect upon the influence of history, research and procedures upon contemporary public health practice. The text explores the debates surrounding the meaning of public health and looks at the policy changes that are reshaping its context. Also examined are the contributions that epidemiology and health economics make to public health.

Paperback £25.99
2007 242pp

ISBN: 978-0-335-22207-0
eBook: 978-0-335-23011-2
amazonkindle **Reference Tree**



An Introduction to Public Health and Epidemiology 2/e

Susan Carr, Nigel Unwin and
Tanja Pless-Mulloli
Northumbria University;
Newcastle University; Newcastle
University, UK

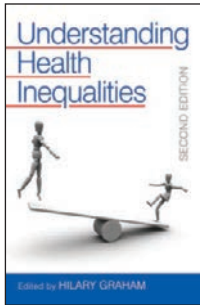
"The contents are not specifically nursing orientated but very neatly balanced to be of relevance

to all working in the public health arena...the book is well written, the language is clear, and the concepts clearly and simply explained and easily understood"
Journal of Biosocial Science

This bestselling book provides a multi-professional introduction to the key concepts in public health and epidemiology. It presents a broad, interactive account of contemporary public health, placing an emphasis on developing public health skills and stimulating the reader to think through the issues for themselves.

Paperback £22.99
2007 192pp

ISBN: 978-0-335-21624-6
eBook: 978-0-335-23385-4



Understanding Health Inequalities 2/e

Hilary Graham (Ed)
University of York, UK

This book provides an engaging exploration of why the opportunity to live a long and healthy life remains profoundly unequal. Hilary Graham and her contributors outline the enduring link

between people's socioeconomic circumstances and their health and tackle questions at the forefront of research and policy on health inequalities.

All the chapters have been specially written by internationally-recognized researchers in social and health inequalities.

Paperback £26.99
2009 248pp

ISBN: 978-0-335-23459-2
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BESTSELLER

Foundations for Paramedic Practice 2/e A Theoretical Perspective

Amanda Blaber (Ed)
University of Brighton, UK

"This excellent book will resonate with all paramedic students as they develop their practice experience, try to make sense of their clinical activity and deal with the ambiguity that is daily paramedic work when responding to emergency calls."

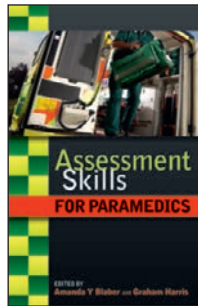
Andy Freeman-May, Senior Lecturer Paramedic Emergency Care, Oxford Brookes University, UK

This popular undergraduate level book introduces the main theoretical subjects studied in higher education paramedic courses. It covers a wide variety of academic subjects, including those not traditionally taught in ambulance 'in-house' training, such as psychology and sociology.

Written by a team of experts from across the UK, the book includes numerous links to practice, illuminating case studies and examples to encourage you to 'stop and think' and reflect upon your practice experience.

Paperback £24.99
2012 304pp

ISBN: 978-0-335-24387-7
eBook: 978-0-335-24390-7
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Assessment Skills for Paramedics

Amanda Blaber and
Graham Harris (Eds)
University of Brighton; University
of Greenwich, UK

"This book provides a helpful and comprehensive insight into the role of the paramedic. It utilizes a variety of experts within the field to illustrate many of

the issues often confronted by those working within this area ... Ideally suited for those starting a career in the out-of-hospital setting, as well as experienced paramedics."

John Donaghy, Principal Lecturer & Professional Lead,
Paramedic Science, University of Hertfordshire, UK

"This book covers every important topic needed to have an appreciation for health related research ... The format is easy to follow and helps the reader to have a foundation knowledge of the language and terminology used within the research world ... This book should be a must have for any student paramedic."

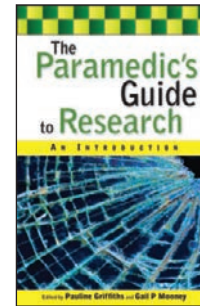
Ruth Lambert, Student, University of Northampton, UK

This concise and accessible book is designed for practicing and student paramedics looking for a quick reference guide to key assessment skills. Divided into body systems, the book takes the reader through the considerations and actions required for each type of emergency presentation.

Using bullet lists, mnemonics, cases and diagrams this is an ideal resource to use for exam and OSCE revision, as well as on the road for those in training or under supervision. Written by a range of expert paramedics working across the UK this is essential reading for new and aspiring paramedics.

Paperback £22.99
2011 328pp

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The Paramedic's Guide to Research An Introduction

Pauline Griffiths and
Gail Mooney (Eds)
Both at Swansea University, UK

"This is an excellent text which covers all of the important research methods in the field, including randomized control trials. A strong component of the

text is the inclusion of chapters on ethics and the future of paramedic research ... The use of paramedic examples throughout the chapters will help students and other budding paramedic researchers connect with the subject matter and help them link theory, evidence and practice."

Professor Peter O'Meara, La Trobe Rural Health School, La Trobe University, Australia

This practical book provides a no nonsense guide for student and qualified paramedics looking to understand the key elements of research, and what it means for their profession. The authors explain key concepts and methodologies to help you get to grips with the nature of paramedic research and how it works in practice.

By drawing on a wealth of cases and examples, research is placed firmly in the context of clinical practice. The book will enable you to critique research and to engage in small-scale research projects of your own.

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Case Book Series

This book is part of a new series of case books written for nursing and other allied health profession students. The books are designed to help students link theory and practice and provide an engaging and focused way to learn.



Paramedics From Street to Emergency Department Case Book

Sarah Fellows and Bob Fellows
Imperial College; University of Hertfordshire, UK

“A great book written by a truly medical family ... The case studies are thought provoking and give an opportunity for students to learn about situations they will encounter during their careers and experienced paramedics and practitioners the opportunity to reflect on similar cases and question their practice.”

Paul Bates, London Ambulance Service, UK

This case book is designed to help paramedics and paramedic students prepare to deal with 25 of the most commonly seen paramedic scenarios, as well as revise for practical exams. Each case study chapter presents clinical information about an emergency call, and the reader must answer questions about the scenario, clinical features, assessment skills and treatments required.

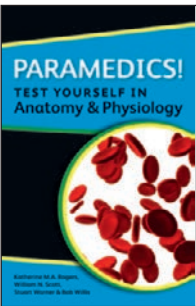
The cases are hugely practical, featuring checklists, clinical tools, key information boxes and clear answers to clinical questions.

Paperback £21.99
2012 176pp

ISBN: 978-0-335-24267-2
eBook: 978-0-335-24268-9
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Paramedics! Test Yourself Series

This brand new series of exam preparation books for paramedics is perfect for helping students revise for exam assessments.



Paramedics! Test Yourself in Anatomy and Physiology

Katherine Rogers, William Scott, Stuart Warner and Bob Willis
Queen's University Belfast; Queen's University Belfast; South Central Ambulance Service and the University of Portsmouth; University of Northampton, UK

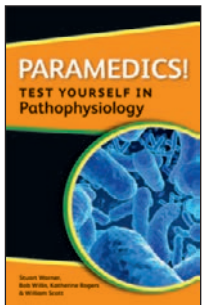
“A highly beneficial and interesting resource to test my own knowledge as it is easy to forget the basics and underlying anatomy and physiology of body systems and I would especially recommend this text to all student paramedics”
Amazon reviewer

This test book is designed to help paramedic students revise for and excel in their anatomy and physiology modules and exams. Crammed full of over 450 questions about A&P, the book also includes fully explained answers and explanations to help consolidate learning as you test yourself.

Each chapter includes MCQs, True or False questions, Fill in the Blanks and Labelling exercises, and there is anatomy artwork to bring concepts to life. An extensive glossary explains all the key terms.

Paperback £14.99
2011 192pp

ISBN: 978-0-335-24370-9
eBook: 978-0-335-24371-6
amazonkindle CourseSmart*



Paramedics! Test Yourself in Pathophysiology

Katherine Rogers, William Scott, Stuart Warner and Bob Willis
Queen's University Belfast; Queen's University Belfast; South Central Ambulance Service and the University of Portsmouth; University of Northampton, UK

This test book is designed to help paramedic students revise for and excel in their pathophysiology modules and exams. With over 300 questions about pathophysiology, the book also includes fully explained answers and explanations to help consolidate learning as you test yourself.

The book covers the most common presentations seen in paramedic practice, and each chapter includes MCQs, True or False questions and Fill in the Blanks to make learning varied and fun. An extensive glossary explains all the key terms and disease names.

Paperback £14.99
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ISBN: 978-0-335-24451-5
eBook: 978-0-335-24452-2
amazonkindle CourseSmart*

NEW EDITION

A Beginner's Guide to Evidence-Based Practice in Health and Social Care 2/e

Helen Aveyard and Pam Sharp
Both at Oxford Brookes University, UK

Have you heard of evidence based practice

but don't know what it means? Are you having trouble relating evidence to your practice?

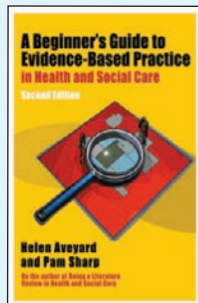
This is the book for anyone who has ever wondered what evidence based practice is or how to relate it to practice. Fully updated in this brand new edition, this book is simple and easy to understand – and designed to help those new to the topic to apply the concept to their practice and learning with ease. This new edition features:

- Additional material on literature reviews and searching for literature
- Even more examples for health and social care practice
- Extra material on qualitative research and evidence based practice
- Expanded section on hierarchies of evidence and how to use them

Contents: Introduction / What is evidence based practice? / Where did evidence based practice come from? / Using evidence in your decision making and to answer practical questions / What are the different types of research and how do they help us answer different questions? / How do I find relevant evidence to support my practice and learning? / How do I know if the evidence is convincing and useful? / How to implement evidence based practice / Glossary / References / Appendix: Useful websites

Paperback £21.99
April 2013 258pp

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NEW

Quantitative Health Research Issues and Methods

Elizabeth Curtis and Jonathan Drennan (Eds)
University of Dublin; University College Dublin, UK

This book gives an in depth but broad guide to undertaking quantitative health research methods at postgraduate level. With the emphasis on the practicalities of doing

research in practice, this text guides readers through:

- Key methods in quantitative research
- Topical issues in health research
- Varying methods for planning a research project
- How to complete research projects as planned

Each chapter includes real life research examples to illustrate good and bad practice for readers to draw from as well as tips and insights into research planning and execution.

Contents: Part 1: Planning / Philosophical basis for research / The importance and use of theory in nursing research / Identifying research problems - reviewing research priorities / Writing research questions and hypotheses / Part 2: Ethical considerations / Ethical principles in research / Recruiting samples from vulnerable groups / Communicating with research ethics committees / Part 3: Design issues / Designing and conducting quantitative research studies / Sampling issues / Planning and conducting surveys / Innovative designs for health care research / Audit as research / Evaluation research / Part 4: Measurement / Cognitive interviewing research / Questionnaires and instruments for health care research / Issues and debates in validity and reliability / Part 5: Data analysis, interpretation and presentation / Understanding probability / Analysing data from small samples and non-normal distributions / Secondary data analysis / Presenting your data

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NEW

How to Write Well A Guide for Health and Social Care Students

June Keeling, Hazel Chapman and Julie Williams
All at the University of Chester, UK

Good writing skills are essential for all students, but many students struggle to master good

writing skills until later in their course. This book will help students doing health and social care subjects to better understand what good writing looks like, and how to do it themselves. The book shows students how to:

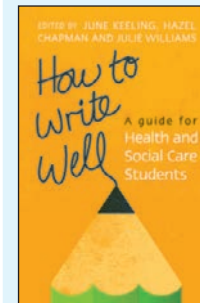
- Plan pieces of writing
- Execute good writing basics
- Edit and refine their work
- Write a brief

Taking an accessible approach, the authors include quotes and stories from real life students to help embolden students to tackle their writing fears – and become confident writers.

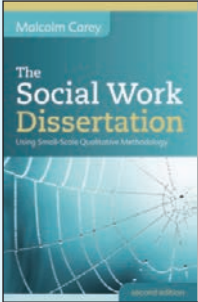
Contents: Introduction / Preparation for writing / Basic writing skills / Advancing your writing skills / What is reflective writing? / Writing for practice / Presenting your writing in different formats / Student's stories / Conclusion

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NEW EDITION



The Social Work Dissertation
Using Small-Scale Qualitative Methodology

The Social Work Dissertation 2/e
Using Small-Scale Qualitative Methodology

Malcolm Carey
University of Manchester, UK

The second edition of this popular book equips students and practitioners within social work with the skills and knowledge to effectively undertake research and complete their dissertation. Written in a clear and straightforward way, the book demystifies tasks which may at first seem difficult, such as the literature review or interviews with practitioners. Topics include:

- Deciding a topic
- Setting a research question and clear objectives
- The stages followed whilst completing a dissertation
- How to undertake a literature review
- Analysis and writing up
- Ethical issues

Contents: Social work research and the dissertation / The research process for a social work dissertation / Key concepts in social work research / Theory and social work research / The literature review and literature based dissertations / Social work methodology / Traditional methods: Interviews, questionnaires and focus groups / Alternative methodology: Narrative research, discourse analysis and life histories / Qualitative analysis / Writing up and dissemination

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Doing Social Work Research

Roger Smith
De Montfort University, UK

Social work research is shown in this book to be both a distinctive academic enterprise and a task that can be accomplished effectively in line with the values and ethical principles that lie at the discipline's core.

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NEW EDITION



SPSS Survival Manual 5/e

SPSS Survival Manual 5/e

Julie Pallant
University of Melbourne, Australia

The *SPSS Survival Manual* throws a lifeline to students and researchers grappling with this powerful data analysis software.

In her bestselling guide, now covering up to version 21 of the SPSS software, Julie Pallant guides you through the entire research process, helping you choose the right data analysis technique for your project. From the formulation of research questions, to the design of the study and analysis of data, to reporting the results, Julie discusses basic and advanced statistical techniques. She outlines each technique clearly, with step by step procedures for performing the analysis, a detailed guide to interpreting data output and an example of how to present the results in a report.

Illustrated with screen grabs, examples of output and tips, the text is supported by a website with sample data and guidelines on report writing.

Paperback £32.99
May 2013 368pp

ISBN: 978-0-335-26258-8
eBook: 978-0-335-26259-5

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Synthesising Qualitative and Quantitative Health Evidence
A Guide to Methods

Catherine Pope, Nick Mays and Jennie Poyay
University of Southampton; LSHTM; University of Lancashire, UK

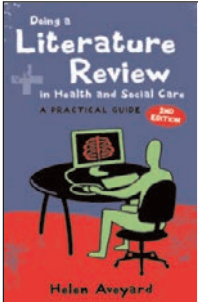
This book provides a comprehensive overview of the range of approaches and methods available for synthesising qualitative and quantitative evidence and a detailed explanation of why this is important.

Paperback £22.99
2007 224pp

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BESTSELLER



Doing a Literature Review in Health and Social Care 2/e A Practical Guide

Doing a Literature Review in Health and Social Care 2/e
A Practical Guide

Helen Aveyard
Oxford Brookes University, UK

"This book is superb. It explains the entire process of writing a literature review very clearly ... extremely helpful as the prospect of reviewing literature can be quite daunting."
Vicky Bain, Student Nurse, University of Nottingham, UK

"A comprehensive, easy to read guide which will help students to understand how to undertake a literature review, and how to use the resultant information effectively."
Anne-Marie Warnes, University of Central Lancashire, UK

This book is a step-by-step guide to doing a literature review in health and social care. The new edition of this popular book has been updated to provide a practical guide to the different types of literature that you may come across and also now contains:

- Examples of commonly occurring real life scenarios encountered by students
- Greater emphasis on the importance of setting a question at the very start of the project
- Advice on how to follow a clearly defined search strategy
- Details of a wide range of critical appraisal tools

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Measuring Health 3/e

Ann Bowling
St George's, University of London, UK

This edition offers a comprehensive guide to measures of health and is an essential reference resource for all health professionals and students. The book contains details of the use of most major measures of health and functioning.

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2004 224pp

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BESTSELLER

A Beginner's Guide to Critical Thinking in Health and Social Care

Helen Aveyard, Pam Sharp and Mary Woolliams
All at Oxford Brookes University, UK

"This book is very well written and laid out. It uses plain English and relies on very little on jargon, therefore making it very readable. I will definitely use it going into my course and would have no hesitation recommending it to course tutors and peers."

Conor Hamilton, Student Nurse, Queen's University Belfast, UK

This is a beginner's guide to the skills of critical thinking, critical writing and critical appraisal in health and social care, and talks you through every stage of becoming a critical thinker. Each chapter tackles a different aspect of the process and using examples and simple language shows you how it's done.

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2011 168pp

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BESTSELLER

Social Research 4/e

Tim May
University of Salford, UK

This fully revised and updated text successfully bridges the gap between theory and methods in social research, clearly illuminating these essential components for understanding the dynamics of social relations.

The book is divided into two parts, with part one examining the issues and

perspectives in social research and part two setting out the methods and processes.

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examples, with additional information on key methodological developments, among them:

- Mixed research methods
- Psychometrics
- Secondary data analysis
- Systematic reviews
- Pertinent social science concepts

The research methods described cover the assessment of health needs, morbidity and mortality trends and rates, costing health services, sampling for survey research, cross-sectional and longitudinal survey design, experimental methods and techniques of group assignment, questionnaire design, interviewing techniques, coding and analysis of quantitative data, methods and analysis of qualitative observational studies, and types of unstructured interviewing.

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Handbook of Health Research Methods Investigation, Measurement and Analysis

Ann Bowling and Shah Ebrahim (Eds)
St George's, University of London; University of Bristol, UK

The book takes a multidisciplinary approach to enable researchers from different disciplines to work side-by-side in the investigation of population health, the evaluation of healthcare, and in healthcare delivery.

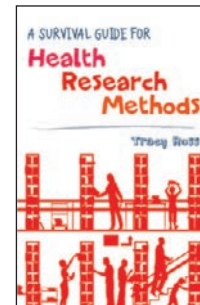
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2005 640pp

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Research Methods in Health 3/e

Ann Bowling
St George's, University of London, UK

This bestselling book provides an accessible introduction to the theoretical concepts and descriptive and analytic research methods used in research on health and health services. The third edition has been thoroughly revised throughout to include updated references and boxed



A Survival Guide for Health Research Methods

Tracy Ross
Glyndwr University, UK

"This is an excellent and much needed book. It has a clear and logical structure that leads you through the knowledge base needed to critically appraise and evaluate clinical research

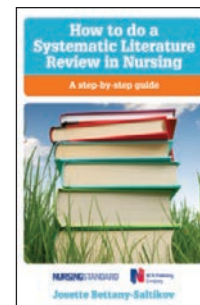
studies ... Each section has brief measurable learning outcomes to give the learning focus and particularly helpful is the "Jargon Busting" glossary placed at the end of each chapter ... This is the book I wish I had written."

Christine Lorraine Carline, Senior Lecturer, Faculty of Health, Staffordshire University, UK

This handy book is an ideal companion for all health and nursing students looking for an accessible guide to research. Written in a friendly style, the book takes the stress out of research learning by offering realistic, practical guidance and demystifying research methods jargon.

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How to do a Systematic Literature Review in Nursing A Step-By-Step Guide

Josette Bettany-Saltikov
University of Teesside, UK

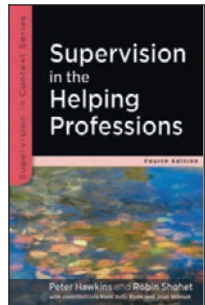
This must buy step-by-step guide to doing a literature review in nursing takes you through every step of the

process from start to finish. From writing your review question to writing up your review, this practical book is the perfect workbook companion if you are doing your first literature review for study or clinical practice improvement.

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Supervision in the Helping Professions 4/e
Peter Hawkins and Robin Shohet
Bath Consultancy Group; Centre for Supervision and Team Development, UK

"This book remains a seminal text in supervision. In the fourth edition the authors bring a contemporary perspective to bear on supervision with an emphasis on the wider contextual and cultural contexts of our work as supervisors. I appreciate above all the 'fearless compassion' with which the authors have addressed the challenges that face us as supervisors in a global culture, and at the same time their ongoing stress on integrating the 'emotional and the rational, the personal and the organizational' in a very accessible model of supervision."
Professor Maria Gilbert, Metanoia Institute, West London, UK

The new edition of this bestselling book is thoroughly updated with references to new developments and writing in the field.

The seven-eyed supervision model which is at the core of the book has been expanded and developed to reflect its use in many professions and different parts of the world. The authors have also incorporated view points from other academics who have constructively observed the model.

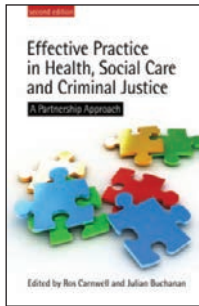
The authors have added a number of new approaches, models and techniques including:

- Techniques for supervising in groups
- The CLEAR model for structuring the process of a supervision session
- How to adapt supervision to learning styles
- How to use video and interpersonal process recall in training supervisors
- Material on research and action research in supervision
- Expansion of the chapter on working transculturally to include analysis of the challenges of working with asylum seekers and refugees

Paperback £26.99
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Effective Practice in Health, Social Care and Criminal Justice 2/e
Ros Carnwell and Julian Buchanan
Both at Glyndwr University, UK

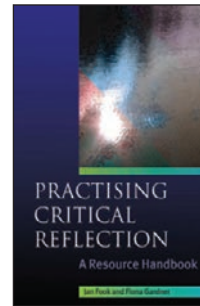
"Contemporary health and social care requires practitioners to develop effective partnerships with patients and clients and with the wider service workforce. This text is designed to promote the development of such partnerships and demonstrates the ways in which partnership can work effectively in practice ... This text is clearly written with all the health and social care professions in mind and will prove to be an invaluable resource for students and trained staff alike."
Margaret Chambers, Lecturer in Children's Nursing, University of Plymouth, UK

Comprehensive yet concise, this text addresses many of the main social and health issues facing society today, and incorporates a practical focus to demonstrate partnership working.

This popular book has been updated to include new chapters on the partnership approach in criminal justice and provides a practical and theoretical insight into some of the issues when working in collaborative partnership with other agencies.

Paperback £24.99
2008 312pp

ISBN: 978-0-335-22911-6
eBook: 978-0-335-23753-1



Practising Critical Reflection
A Resource Handbook

Jan Fook and Fiona Gardner
South West London Academic Network, UK; La Trobe University, Australia

This accessible handbook focuses on a description and analysis of the theoretical input as well as the approach involved in critical reflection.

It also demonstrates some skills, strategies and tools which might be used to practise it.

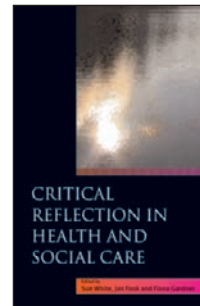
The cross-disciplinary approach taken by the authors will appeal to a wide range of students and professionals. A website containing a variety of useful resources accompanies the book:

www.openup.co.uk/fook&gardner

Paperback £24.99
2007 232pp

ISBN: 978-0-335-22170-7
eBook: 978-0-335-23487-5

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Critical Reflection in Health and Social Care

Sue White, Jan Fook and Fiona Gardner (Eds)
Lancaster University, UK; South West London Academic Network, UK; La Trobe University, Australia

"... the book makes an excellent contribution to the library of those keen to delve further into the realm

of critical reflection, understand various interpretations of interdisciplinary practices, and use these to aid their own and others' professional practice, exploration and development."
Learning in Health and Social Care

This book arises out of the editors' teaching and research experience in professional education. It showcases current work with critical reflection which is taking place internationally and across disciplines in health and social care.

Paperback £24.99
2006 288p

ISBN: 978-0-335-21878-3
eBook: 978-0-335-22840-9



BESTSELLER

Child Abuse 4/e

Brian Corby, David Shemmings and David Wilkins

Late of University of Central Lancashire; University of Kent; University of Kent, UK

"This text stands out in the field [due to] its comprehensiveness. This updated edition should prove invaluable to students, academics, policy makers and professionals across many jurisdictions."

Helen Buckley, Associate

Professor and Co-ordinator, Postgraduate Diploma in Child Protection and Welfare, Trinity College Dublin, Ireland

"There are many valuable Child Abuse or Child Protection texts available on the market, however very few successful provide a comprehensive resource to support both. Not only does this book provide an excellent insight into the subject of Child Abuse, but it also explores the current difficulties within Safeguarding Children and Child Protection practice, with clear explanation of legislative changes and the modern challenges faced."

Amy Dopson, Child Branch Leader Professional Preparation Nursing, University of Surrey, UK

This seminal text on theory and research has been fully updated in terms of policy, cases and research. The authors provide a knowledge base for the whole area of child abuse and child protection which is accessible to both the qualified experienced practitioner and in-experienced student, in particular the use of clear examples used to highlight a discussion or point. The book provides:

- Summaries of content at the beginning of each chapter
- Detailed history chapters with chronologies at the end
- Critical debate / standpoint on research studies and statistics
- Comprehensive coverage of relevant issues, historical and contemporary
- Extensive bibliography

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**Working with Adults at Risk of Harm**

Margaret Greenfields, Roger Dalrymple and Agnes Fanning (Eds)
All at Buckinghamshire New University, UK

"This important book brings together valuable resources and insights in a key area of practice which has often been

overlooked, and where disadvantage and discrimination are rife, but which also deserves and demands serious attention of the kind offered here."
Roger Smith, Professor of Social Work Research, De Montfort University, UK

This comprehensive book uniquely acknowledges the overlap between different states of adult vulnerability within a range of health, social care and community contexts. The book looks beyond social work practice and legislative focus to examine the categories of 'at risk' and 'vulnerable adults'. These include often forgotten groups such as homeless people, prisoners and migrant workers.

Through a range of practical examples, the book illustrates how professionals can usefully and effectively intervene to lessen the chance of a member of an excluded community becoming at greater 'risk' of further vulnerability.

The book includes:

- Explanations of core themes and implications for a range of professionals and service providers with a practical and accessible focus
- Case studies and practice examples from work with vulnerable groups
- Illustrative examples of how different states of vulnerability are frequently contingent upon one another

Working with Adults at Risk of Harm is ideal for third-year undergraduate students and Master's students in the fields of social work, social care, community health and education, as well as staff working in public sector who will have contact with vulnerable individuals in their professional life.

Paperback £22.99
2011 296pp

ISBN: 978-0-335-24122-4
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**Safeguarding and Child Protection for Nurses, Midwives and Health Visitors A Practical Guide**

Catherine Powell
NHS Portsmouth and Solent Healthcare, UK

"Catherine Powell has produced a superbly useful text ... The organization and layout is highly user-friendly and it represents an up to the minute guide absolutely rooted in practice."

Jan Nelmes, Senior Lecturer, University of Brighton, UK

"All nurses have a duty to inform and alert appropriate personnel if they suspect a child has been abused, and to know where they can seek expert advice and support if they have concerns. This comprehensive text providing the link between legislation, policy, research and practice will enable students and practitioners to expand their knowledge and understanding of the key issues involved in safeguarding children and young people."

Fiona Smith, Adviser in Children and Young People's Nursing, Royal College of Nursing, UK

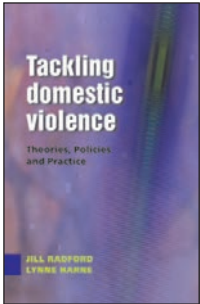
Nurses, midwives and health visitors have a statutory duty to safeguard and promote the welfare of children and young people. In this clear and invaluable guide, Catherine Powell focuses on the practical aspects of safeguarding and how healthcare professionals should respond to safeguarding children concerns.

The book covers the full spectrum of safeguarding children work; from prevention and early help through to statutory intervention and serious case review. The book includes:

- Realistic case scenarios
- The roles and responsibilities of nurses, midwives and health visitors working in a range of settings
- Crucial chapters on integrated working and supervision and support in safeguarding
- 'Points for Practice', 'Practice Questions' and 'Markers of Good Practice'

Paperback £22.99
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Tackling Domestic Violence Theories, Policies and Practice

Lynne Harne and Jill Radford
*Roehampton University; University
of Teesside, UK*

This accessible text takes a multi-disciplinary approach to exploring issues surrounding domestic violence. It draws on contemporary research

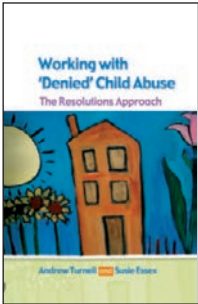
findings, policy developments, innovative practice and case studies to explore new directions in professional and voluntary sector responses to domestic violence. Centred on the UK, but located in a context of global change, the book discusses and critically evaluates new criminal justice and multi-agency initiatives such as domestic violence courts and risk assessment conferences, as well as assessing how far these initiatives improve the safety of women and children.

Harne and Radford aim to disseminate ideas about best practice in relation to dealing with this sensitive and still controversial issue. They use real-life case studies from professionals, including the police, health services and Women's Aid, and are inclusive of the experiences of a wide range of survivors, in order to enable an understanding of the need for appropriate responses, depending on different survivor needs.

Tackling Domestic Violence provides an informed background for professionals in the police, probation, health and social care services, the legal system and voluntary sector with a remit to respond to domestic violence.

Paperback £24.99
2008 216pp

ISBN: 978-0-335-21248-4
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Working with Denied Child Abuse The Resolutions Approach

Andrew Turnell and
Susie Essex
*Resolutions Consultancy, Perth,
Australia; Consultant Family
Therapist, North Bristol CAMHS, UK*

Situations where parents refute child abuse allegations made against them are often deemed to be impossible or untreatable by statutory and treatment professionals. This book presents an innovative, safety-focused, partnership-based, model called Resolutions, which provides an alternative approach for responding rigorously and creatively to such cases.

Paperback £24.99
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Safeguarding Children and Young People A Guide for Nurses and Midwives

Catherine Powell
*NHS Portsmouth and Solent
Healthcare, UK*

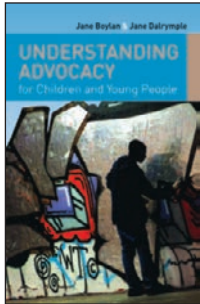
*"This book should be
available in every ward,
clinic and department. ...*

This book is comprehensive and, that rare thing in nursing literature, scholarly and authoritative. ... reading this book should arm nurses with the understanding to effectively do their duty and safeguard children."
Paediatric Nursing

While many nurses and midwives are in an ideal position to prevent, identify and respond to child maltreatment, they may not currently have a clear understanding of the theory, policy and practice of safeguarding children. This book provides an accessible text that outlines and explores professional roles and responsibilities in the context of inter-agency working.

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2007 224pp

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Understanding Advocacy for Children and Young People

Jane Boylan and
Jane Dalrymple
*University of Keele; University of
the West of England, UK*

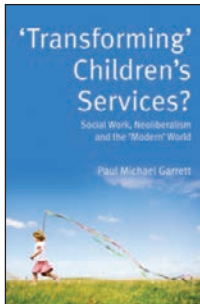
Presenting children and young people's advocacy as an exciting, radical and

constantly developing way of working, Boylan and Dalrymple explore its controversial and challenging nature through a comprehensive examination of the theory and practice of advocacy.

Readers are invited to consider advocacy as a powerful tool for promoting change in attitudes towards children and young people.

Paperback £23.99
2009 160pp

ISBN: 978-0-335-22373-2
eBook: 978-0-335-23919-1



'Transforming' Children's Services? Social Work, Neoliberalism and the 'Modern' World

Paul Michael Garrett
National University of Ireland

The author argues that the many changes which have taken place within, and

beyond, Children's Services are related to the politics of Neoliberalism which, it is maintained, lie at the core of the Change for Children programme. Readers will find detailed discussion on:

- The *Laming Report* which examined the death of Victoria Climbié
- The case of 'Baby P'
- Social work's 'electronic turn' and the use of ICTs in Children's Services
- More pervasive patterns of surveillance
- How 'ASBO politics' has influenced the 'transformation' agenda

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NEW

Health System Performance Comparison

An Agenda for Policy, Information and Research

Irene Papanicolaou and Peter Smith (Eds)
London School of Economics and Political Science; Imperial College of Science, Technology and Medicine, UK



This book assesses the 'state of the art' of health system performance comparison as well as the priorities for future research and policy. Throughout, the emphasis is on performance information that sheds light on comparative system performance.

Aiming to assist policy makers and those studying health systems and health policy, this book:

- Assesses the strengths and limitations of existing conceptual frameworks for thinking about health systems and assessing performance
- Examines the existing indicators in use, the gaps and limitations
- Identifies methodological weaknesses in existing performance measurement initiatives, and assesses the scope for future improvements
- Assesses the priorities for future initiatives in data collection, analytic methodology and policy uses

Contents: Foreword by Zsuzanna Jakab / Foreword by Paola Testori Coggi / Foreword by Mark Pearson / Introduction / International frameworks for health system comparison / International comparisons of health systems / Benchmarking: lessons and implications for health systems / Comparing population health / Comparing health services outcomes / Conceptualizing and comparing equity across nations / Measuring and comparing financial protection / Understanding satisfaction, responsiveness and experience with the health system / Comparative measures of health system efficiency / Commentary on international health system performance information / Conclusions

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NEW

Success and Failures of Health Policy in Europe

Four Decades of Divergent Trends and Converging Challenges

Johan Mackenbach and Martin McKee (Eds)
Both at LSTHM, UK



An analysis of successes and failures is important for several reasons. It helps to identify 'best practices', from which other countries can learn, and which can be implemented more widely to improve population health. It will provide a basis for looking behind the specific policies to identify why some countries implement more effective health policies than others, such as strength of the public sector, barriers to intersectoral action and the role of health professionals. This book brings together the results of recent comparative studies of health policies and population health in Europe in order to identify the successes and failures of national health policies, and to investigate the institutional and other determinants of success.

Contents: Introduction / Tobacco / Alcohol / Food and nutrition / Fertility, pregnancy and childbirth / Child health / Infectious disease / Hypertension / Cancer screening / Mental health / Road traffic injuries / Air pollution / Comparative analysis of national health policies / Past and future health gains / The will and the means to implement health policies / Conditions for successful health policies / Conclusions

Paperback £29.99
March 2013 320pp

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eBook: 978-0-335-24752-3
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Diagnosis Related Groups in Europe

Reinhard Busse, Alexander Geissler, Wilm Quentin and Miriam Wiley (Eds)
All at Berlin Technical University, Germany

This book is a product of the EuroDRG project and constitutes an important resource for health policy-

makers and researchers from Europe and beyond. The book is intended to contribute to the emergence of a 'common language' that will facilitate communication between researchers and policy-makers interested in improving the functioning and resourcing of the acute hospital sector.

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WHO; WHO; NIVEL, Netherlands; International Organization for Migration; International Organization for Migration; LSHTM, UK

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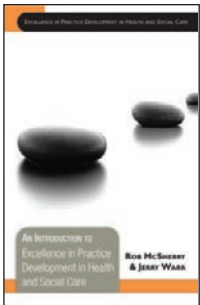
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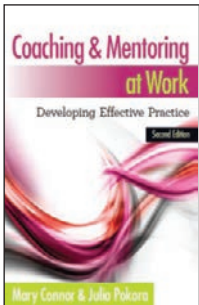
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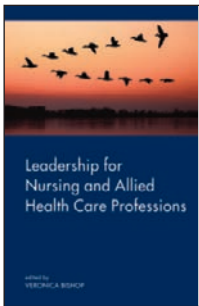
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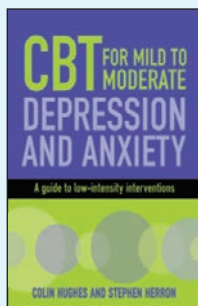
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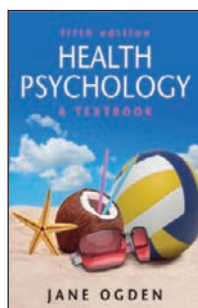
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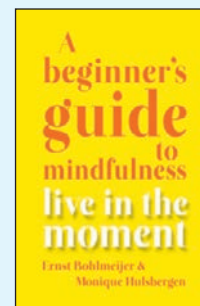
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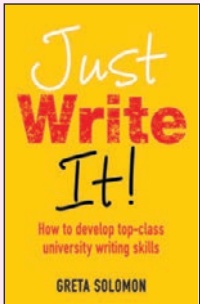
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A

Analytical Models for Decision-Making 19
Arnott, J, Atherley, S, Pye, S and Kelly, J 6
 Art and Science of Mental Health
 Nursing 3/e, The 1, 9
 Assessment Skills for Paramedics 21
Aston, L and Strouther, L 2
Aston, L, Wakefield, J and McGown, R 6
Aveyard, H 24
Aveyard, H and Sharp, P 7, 11, 23
Aveyard, H, Sharp, P and Woolliams, M 25

B

Baldwin, C and Capstick, A 16
Ball, D 19
Barber, P 5
Barber, P and Roberston, D 2
Barber, P, Parkes, J and Blundell, D 2
Barcham, C 10
 Beginner's Guide to Critical Thinking in Health
 and Social Care, A 25
 Beginner's Guide to Evidence-based Practice in
 Health and Social Care 2/e, A 7, 11, 23
Berridge, V, Gorsky, M and Mold, A 18
Bettany-Saltikov, J 2, 25
Bishop, V 30
Blaber, A 21
Blaber, A and Harris, G 21
Bohlmeijer, E and Hulsbergen, M 31
Bond, M and Holland, S 7
Bowling, A 24, 25
Bowling, A and Ebrahim, S 25
Boylan, J and Dalrymple, J 28
Buckroyd, J 31
Buse, K, Mays, N and Walt, G 19
Busse, R, Geissler, A, Quentin, W and Wiley, M 29

C

Cantley, C 16
Carey, M 24
Carneiro, I and Howard, N 18
Carnwell, R and Buchanan, J 26
Carr, S Unwin, N and Pless-Mulloli, T 20
Cassedy, P 7
Cattan, M 16
 Child Abuse 4/e 27
 Clinical Judgement and Decision-Making in
 Nursing and Interprofessional Healthcare 7
 Clinical Skills 8

Coaching and Mentoring at Work 2/e 30
 Cognitive Behavioural Therapy for Mild to
 Moderate Depression and Anxiety 31
 Communication and the Care of People with
 Dementia 15
 Communication Skills for Adult Nurses 7
 Communication Skills for Children's Nurses 7
 Communication Skills for Mental Health
 Nurses 10
 Communication Skills for Midwives 14
 Competencies for Nursing Practice 1
 Conflict and Health 17
Connor, M and Pokora, J 30
 Controlling Communicable Disease 19
Corby, B, Shemmings, D and Wilkins, D 27
Coulter, A 12
 Counselling Skills 2/e 31
Cranmer, P and Nhemachena, J 1
 Critical Reflection in Health and Social Care 26
Curtis, E and Drennan, J 23

D

Davies, M, Macdowall, W and Cragg, L 17
 Dementia Care Workbook, The 16
 Dementia Reconsidered 16
 Diagnosis Related Groups in Europe 29
Dogra, N and Leighton, S 9
 Doing a Literature Review in Health and Social
 Care 2/e 24
 Doing Social Work Research 24
Downs, M and Bowers, B 15
Durand, M and Chantler, T 17

E

Economic Analysis for Management and
 Policy 19
 Economic Evaluation 19
 Effective Practice in Health, Social Care and
 Criminal Justice 2/e 26
 Engaging Patients in Healthcare 12
England, C and Morgan, R 14
 Environment, Health and Sustainable
 Development 2/e 18
 Environmental Epidemiology 19
 Environmental Health Policy 19
 Essential Calculation Skills for Nurses,
 Midwives and Healthcare Practitioners 8
 Essentials of Pharmacology for Nurses 2/e 2
 Ethics for Nurses 1

Excellence in Dementia Care 15

F

Family Interventions in Mental Health 10
Fellows, S and Fellows, B 13, 22
Figueras, J and McKee, M 30
 Financial Management in Health Services 17
 First Steps in Clinical Supervision 7
Fook, J and Gardner, F 26
 Foundations for Paramedic Practice 2/e 21
Fox-Rushby, J and Cairns, J 19
 Further Essentials of Pharmacology for
 Nurses 2
 Future Public Health, The 20

G

Gardner, E 17
Garrett, P.M 28
Gill, G and Medd, W 32
 Global Change and Health 19
Goodwin, N, Gruen, R and Iles, V 18
Gottwald, M and Goodman-Brown, J 12
Graham, H 20
*Grant, G, Flynn, M, Richardson, M and
 Ramcharan, P* 8
Greenfields, M, Dalrymple, R and Fanning, A 27
Griffiths, P and Mooney, G 21
Gruen, R and Black, N 19
Gruen, R and Howarth, A 17
 Guide to Practical Health Promotion, A 12
Guinness, L and Wiseman, V 18

H

Hallawell, B 5, 13
 Handbook of Dementia Care, A 16
 Handbook of Health Research Methods 25
Hanlon, P, Carlisle, S, Hannah, M and Lyon, A 20
Harne, L and Radford, J 28
Harris, N and Shearer, D 3
Hawkins, P and Shohet, R 26
 Health Care Evaluation 19
 Health Promotion for People with Intellectual
 and Developmental Disabilities 11
 Health Promotion Practice 18
 Health Promotion Theory 2/e 17
 Health Psychology 5/e 31
 Health System Performance Comparison 29
 Health Systems 30
 Healthcare Management 2/e 30

How to do a Systematic Literature Review in Nursing 2, 25
How to Write Well 11, 23
Howard, N, Sondorp, E and Ter Veen, A.M 17
Hughes, C and Herron, S 31
Hutton, M 8

I
Iggulden, H, MacDonald, C and Staniland, K 8
International Public Health Nutrition 17
Introduction to Community Nursing Practice 6
Introduction to Counselling 5/e, An 31
Introduction to Epidemiology 2/e 18
Introduction to Excellence in Practice
Development in Health and Social Care, An 30
Introduction to Health Economics 2/e 18
Introduction to Mental Health Nursing 10
Introduction to Public Health and Epidemiology 2/e, An 20
Issues in Public Health 2/e 18

J K
Jackson, C and Thurgate, C 12
Jan, S, Kumaranayake, L, Roberts, J, Hanson, K and Archibald, K 19
Jordan, S 8
Just Write It! 32
Keady, J, Clarke, C.L and Page, S 16
Keeling, J, Chapman, H and Williams, J 11, 23
Key Debates in Health Care 12
Killick, J and Allan, K 15
Kitwood, T 16
Knifton, L and Quinn, N 9, 20
Kovats, S and Hutchinson, E 18
Kraszewski, S and McEwen, A 7

L
Larkin, M 12
Lambert, V, Long, T and Kelleher, D 7
Law, Values and Practice in Mental Health Nursing 10
Leadership for Nursing and Allied Health Care Professions 30
Learning Disabilities in Health Care Settings 5, 13
Learning Disability 2/e 8
Lee, K and Collin, J 19
Live in the Moment 31
Lloyd, M 5, 10

M
Macdowall, W, Bonnell, C and Davies, M 18
Mackenbach, J and McKee, M 29
Mahon, A, Walshe, K and Chambers, N 30
Making Health Policy 2/e 19
Managing Health Services 18
May, T 25
McLeod, J 31
McLeod, J and McLeod, J 31
McSherry, R and Warr, J 30
Measuring Health 3/e 24
Medical Anthropology 19
Medicine Management for Nurses 5
Mental Health and Well-Being in Later Life 16
Mental Health Nursing 13
Merriman, C and Westcott, L 6
Midwifery Practice 13, 14
Midwifery Testbook, The 14
Migration and Health in the European Union 29
Morris, G and Morris, J 16
Morrissey, J and Callaghan, P 10
Murray, C, Rosen, L and Staniland, K 6
Murray, R 32

N
Nash, M 15
Noah, N 19
Norman, I and Rylie, I 1, 9
Nurse Mentor and Reviewer Update Book, The 6
Nurse Mentor's Handbook, The 6
Nurses! Test Yourself in Anatomy and Physiology 4
Nurses! Test Yourself in Clinical Skills 3
Nurses! Test Yourself in Essential Calculation Skills 4
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Nurses! Test Yourself in Pathophysiology 4
Nurses! Test Yourself in Pharmacology 3
Nursing in Child and Adolescent Mental Health 9
Nursing Older Adults 15
Nursing the Acutely Ill Adult 6, 13

O P
Ogden, J 31
Orme, J, Powell, J, Taylor, P and Grey, M 20
Page, K and McKinney, A 6, 13
Pallant, J 24
Palliative Care Nursing 2/e 8
Papanicolas, I and Smith, P 29
Paramedics 13, 22
Paramedic's Guide to Research, The 21
Paramedics! Test Yourself in Anatomy and Physiology 22
Paramedics! Test Yourself in Pathophysiology 22
Parsons, G and Preece, W 8
Partnerships in Community Mental Health Nursing and Dementia Care 16
Payne, S, Seymour, J and Ingleton, C 8
Pecorari, D 32
Perioperative Practice 5, 13
Physical Health and Well-Being in Mental Health Nursing 15
Pocketbook Guide to Mental Health Act Assessments, The 10
Pool, R and Geissler, W 19
Pope, C, Mays, N and Poyay, J 24
Powell, C 27, 28
Practical Care Planning for Personalized Mental Health Care 10
Practical Guide to Care Planning in Health and Social Care, A 5
Practising Critical Reflection 26
Prescription Drug Guide for Nurses, The 8
Principles and Practice of Managing Pain 8
Principles of Social Research 2/e 17
Psychological Interventions in Mental Health Nursing 10
Psychology for Midwives 14
Psychology for Nurses and the Caring Professions 4/e 2
Psychosocial Nursing 9
Public Health for the 21st Century 2/e 20
Public Health in History 18
Public Mental Health 9, 20

Q R
Quantitative Health Research Methods 23
Raynor, M and England, C 14
Raynor, M, Marshall, J and Jackson, K 13, 14
Reader in Health Policy and Management, A 30

Reading, S and Webster, B.J. 1
Rechel, B, Mladovsky, P, Devillé, W, Rijks, B, McKee, R.M 29
Reed, J, Clarke, C and MacFarlane, A 15
 Reflective Practice for Healthcare Professionals 3/e 6
 Research Methods in Health 3/e 25
Roberts, D 9
Rogers, A and Pilgrim, D 15
Rogers, K 3
Rogers, K and Scott, W 4
Rogers, K, Scott, W, Warner, S and Willis, B 22
Ross, T 25
S
 Safeguarding and Child Protection for Nurses, Midwives and Health Visitors 27
 Safeguarding Children and Young People 28
Sanderson, C and Gruen, R 19
 Sexual Health 18
Sim, F and Mckee, M 18
 Skills of Clinical Supervision for Nurses 2/e 7
Smith, G 10
Smith, R 24
Smith, S, Sinclair, D, Raine, R and Reeves, B 19
 Social Aspects of Health, Illness and Healthcare 12
 Social Research 4/e 25
 Social Work Dissertation 2/e, The 24
 Sociology of Mental Health and Illness 4/e, A 15
Solomon, G 32
 SPSS Survival Manual 5/e 24
Standing, M 7
Strong, P and Hughes, S.J 5, 13
 Student Nurse Guide to Decision Making in Practice, The 6
 Student Nurse Handbook, The 2
 Succeed in OSCEs and Practical Exams 6
 Success and Failures of Health Policy in Europe 29
 Supervision in the Helping Professions 4/e 26
 Survival Guide for Health Research Methods, A 25
 Synthesising Qualitative and Quantitative Health Evidence 24

T
 Tackling Domestic Violence 28
Taggart, L and Cousins, W 11
Taylor, B 6
Taylor, G and Hawley, H 12
 Teaching to Avoid Plagiarism 32
Timmins, F and Duffy, A 2
 Tom Kitwood on Dementia 16
 Transforming' Children's Services? 28
Traynor, M 3
Turnell, A and Essex, S 28

U
 Understanding Advocacy for Children and Young People 28
 Understanding Health Inequalities 2/e 20
 Understanding Health Services 19
 Understanding Your Eating 31

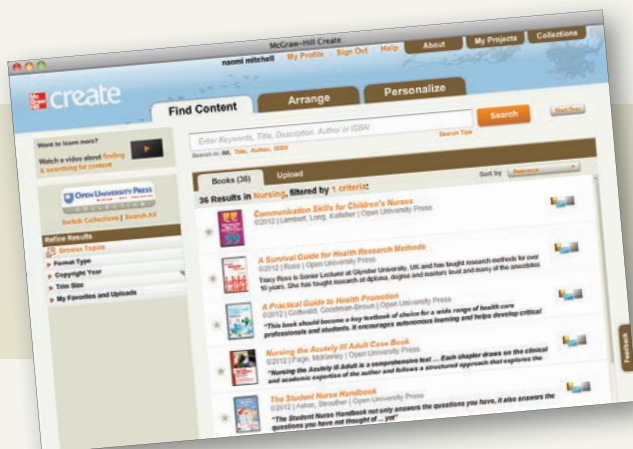
W/Y
Walker, J, Payne, S, Jarrett, N and Ley, T 2
Walsh, D 6
Walshe, K and Smith, J 30
Wellings, K, Collumbien, M and Mitchell, K 18
White, S, Fook, J and Gardner, F 26
Wightman, H and Aslam, R 14
Wilkinson, P 19
Williamson, T and Daw, R 10
Withnell, N and Murphy, N 10
 Working with Adults at Risk of Harm 27
 Working with Denied Child Abuse 28
 Workplace Learning in Health and Social Care 12
 Writing for Academic Journals 3/e 32
 Writing Your Nursing Portfolio 2
Wrycraft, N 10, 13
 Your PhD Coach 32



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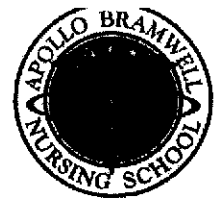
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Unit V

Vocabulary

- Conversation
- Speaking Skills

Unit V1

- Vocabulary in the good manner
- Words for the statement: how to ask, claim, convince, reassure...
- 1st impression: each employee is the window of the enterprise.

The positive attitude: a frame of mind which makes all the differences

- Needs of the customer
- How to deal with a customer: smile, body language, selected words
- Rules for a good communication
- The telephone reception: on the telephone the smile gets along, the importance of the 1st contact, how to make, receive, transfer and conclude a call.
- The telephone vocabulary
- Listening: how to identify a request, to know to reformulate, know to channel
- How to manage a customer.

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c/o Apollo Bramwell Hospital, Moka, Mauritius - T: (230) 605 1080 - F: (230) 433 3350
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BRC No.: C08074963

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C/O APOLLO BRAMWELL HOSPITAL, ROYAL ROAD, MOKA

N1007 – INFORMATION TECHNOLOGY & COMMUNICATION SKILLS
(A Resource Unit)

Module Code: NURS 1007

Module Name: Information Technology and Communication Skills

Description:

Writing of report using appropriate English Language, grammar and vocabulary; enhancing verbal communication skills. Use of the computer and managing files: Applications of basic programmes [Word, Excel, PowerPoint]

Credit: 1.5 units (30 contact hours)

Placement: First Year, First Semester

Settings: Classroom and Computer Lab

Requirements: Continuous Assessment Assignment/Essay writing - 50%
Tests (Vocabulary and Grammar) - 20%
Group Presentation - 30%

For IT classes: attendance at and participation in at least 90% of all scheduled teaching activities is compulsory.

Students must score at least 50% in the both continuous and end-of-term assessment

- 201kan
- 20hmin

800-8000 WMPAS

① 25min MCQs

② 4persu/

③ ESSAY

④ ORAL =

Test / vocabulary & Grammar

1

A
B
C
D

Learning outcomes: At the end of the module, the student will be able to:

1. Understand concepts in information technology, computer fundamentals and use of information technology in the health sector;
2. Demonstrate basic skills in computer use for a more effective contribution to their future organization;
3. Write a report using appropriate English Language, correct grammar and vocabulary;
4. Demonstrate satisfactory ability to communicate verbally and in writing the English Language.

Resources.

PILO, T. (2008) A Complete Guide to G.C.E. 'O' Level English Singapore: Fairfield Book Publishers Pte Ltd.

PILO, T. (2008) Read Up for General Paper. Singapore: Fairfield Book Publishers Pte Ltd.

HARGIE,H.(2007) THE HANDBOOK OF COMMUNICATION SKILLS. London and New York: Routledge Taylor & Francis Group.

N 107

14-04-2014

C. Ayl
det.

call - tomorrow -

Wednesday copies - 16.04.2014

Books

Verbal, written

Communication interview

Health history

Consultant

with

patient

family

professional

? Culture

?

Group
presentation skill

Strategies for handling situations
written at end

Broad base education

like skills - ~~UK~~

1. AA common email - in time) take to

Class

AA common email

Cultural influences

Active listening

with others

disputing → in some cases

meet someone
how you
by ? his preferences

answers
sympathy
so it

answers → ~~part~~
refert
wh learn

I am sorry -
disputing
Lily

problem solver →

Learning

methodology: speak English - learn oral English -

writing then reading - English Newspaper - Re.

Independent - are who articles.

Spends reading exercises

left hand
→
right hand

Reading Exercises

1. Read - words -

2. Listening

① Globalisation

② Democracy -

② QUESTIONS

1. What is globalisation?

a. State two benefits of globalisation?

b. State two drawbacks of globalisation?

c. Differentiate between direct and portfolio foreign investments?

e. Why do you think Vietnam and Laos are among the poorest countries in the world?

Writing of Report using appropriate English Language: Grammar/Vocabulary

WRITTEN KOREAN English

English Language is not your 1st language -
Penalization - grammar - !!!
Punctuations,

HCO - Health care professional -

Standard of Behaviour - legal, medical, political -

kill him, not wait for me -

kill him, not, wait for me.

THE main - Law - Nursing report - Don't put -

Hand we read English =

Communication with - Doctors Round -
Core principles

I: Ask to rephrase -

1. Statistics

2. References

3. Harvard referencing system -

4.

PPE
EOTA
CA VPA
TRAS -

VIVA -

✓

1

✓

4

Research

✓

0

L

Nurs1007

E

PRESENTATION
PONGR -
Dont

Nims1007.

14-4-15

C. AuB

OED - educated system - problem this -

Punctuation -

#Professional, nursing English

OBSERVATION, UK.

Vital Signs - US. Colonoscopy - Aus -

Endoscopy - Stomach -

Central line. line -

Two days introduction

NURS1001

Monday 14 April 2014
NTP-1.

C. AUBOOL
MARE

Concept of health & wellness
What does it mean to you?

Patients needs -

Course Plan: 6 unit lectures - 2 units skills.
Go/go.

Google Nursing theories -

PDF
Pang and putch
excerpt

compare & contrast concept

Exhibit -

Explain -

Role play.

He say I am more important but you be can.

"The only say I am - agent -

Good Body mechanics

ADL -

NURS1003

Psychosocial context of health and illness -

CHOTAB

15-04-14

Psychosocial Principles

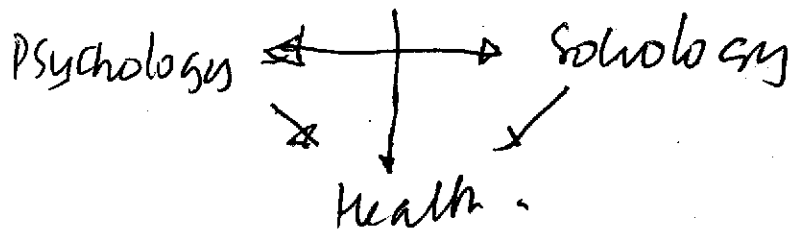
1st year

1st semester

5 credit

75 hrs

1300



The biopsychosocial model of disease

(1) Genetic 40%

(2) Lifestyle 20%

(3) Environment 20%

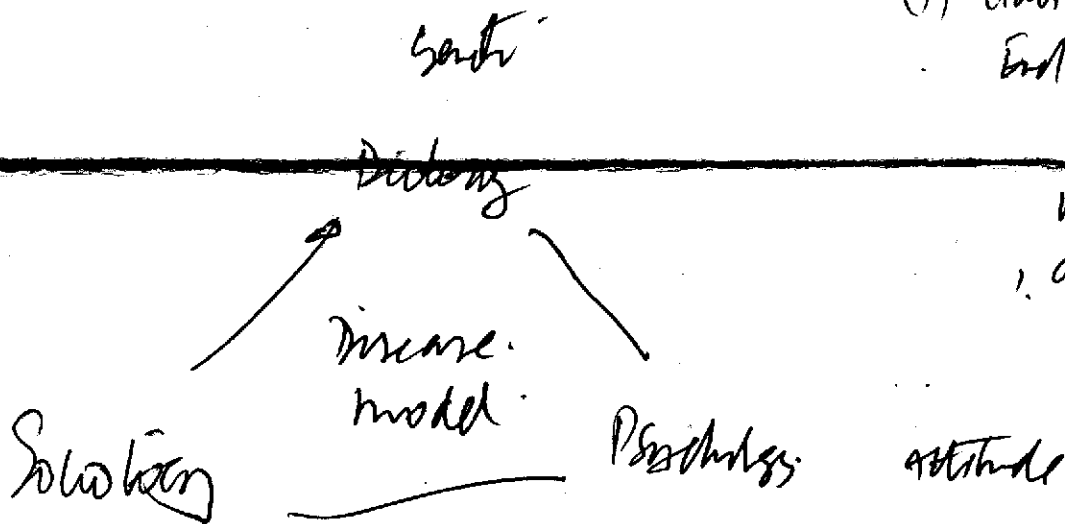
(4) Clinical 20%

End of Genetic Era

100% / 20%

Web site data -

Articles Net -



hurry

The medical support keeps me alive, but it is

the psychological and social support that enable me to live!

HEALTH PROMOTION OF HEALTH GIVING TO THE INDIVIDUAL.

So

That health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity.

Psychosocial health is affected by a number of factors, some internal and others external.

External influences are those parts of our life experiences that we have little or no control over, for instance our family and where we grow up.

Internal factors associated with psychosocial health are equally as important as the external factors; however, they are harder to see as they are inside the person; however they are harder to see as they are internal factors such as self-concept, hereditary traits, physical health status, physical fitness level, hormonal functions, and mental, social, sexual, spiritual and emotional

Psychosocial Context of Health and Illness I

Psychology:

- Introduction
- Definitions, Scope of Psychology and its importance in nursing profession
- Psychology of human behaviours
- Learning
- Observation
- Intelligence
- Personality
- Communication

health all have an impact on the individual's psychosocial health.

Nms103
5 credits

Psychosocial context
of

CHOTAB

15-04-14

1st Y 1st Semester

Health at all times.

Psychology is the scientific study of behaviour.
mental processes. Behaviour includes all of our
outward, ~~upward~~, mental processes refer to internal or
To prove it make a research - evidence based.
practice - Research based - Initially a training
episode - a blood sample is taken then analysed -
identifying what hormones are at work, proteins

In 1986 Virginia Henderson cited Siviter (2004)
stated that: 'Nursing is primarily assisting the
individual in the performance of those

Definition

Health is derived from whole, hale and healthy

depression

mood
swings.

Health & Illness

Sociology

The study of human society — The fabric of society is maintained by institutions. Re.
The dawning of a relationship —

Nature versus nurture.

Psychosocial rehabilitation is the development of skills and supports necessary for successful living, learning, and working in the community.

NR35

Psychosocial health is basically how we see ^{strong} life and our experience and is fundamental in a person's general well-being, encompassing mental, emotional, social and spiritual aspects of health.

The roots of the term psychosocial health lie in the World Health Organization's (1948) definition of health which states that health is a state

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SYLLABUS

NURS 1003 Psychosocial Context of Health and Illness

MODULE CONTENT

Aim

This module will highlight the importance of Sociology and psychology to understand the context in which individual and family health occurs and provide a basic framework for assessing health in the various dimensions: Physical, Psycho-emotional, Spiritual and Socio-Cultural.

Learning Outcomes

The students will be able

- Apply the psychosocial principles while performance nursing duties.
- Differentiate how sociological and psychological processes contribute towards well being and illness.
- Understand the psychodynamics of human behaviour.
- Describe the main institutions of the society, their structure and ~~structure~~ *and importance.*
- Identify the psychological and sociological needs of the clients to help in planning their nursing.
- Understand the communication process and develop the necessary skills to communicate effectively.
- Develop positive attitudes towards individual, family and the community.

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Module Content

Psychology

Unit I

Introduction

- **Definitions, scope of psychology and its importance in nursing profession**

Unit II

Psychology of Human Behaviours

- **Dynamics of behaviour, motivation and behavioural process of adjustment, adjustments and mal-adjustments, unconscious behaviour.**
- **Frustration: Sources and nature of frustration, measures to overcome frustration.**
- **Conflict: types, unconscious conflict, resolution, conflict and nursing.**
- **Adjustment Mechanism: meaning, types and importance.**
- **Emotions: in health and disease, emotional situations, control of emotions, effect of emotional reactions to health.**
- **Attitudes: meaning, development, changes in attitude, attitude and nursing.**
- **Habits: formation, types, effective habit formation, advantages and disadvantages of habit formation.**

Unit III

Learning

- **Nature of learning, law and types of learning, factors promoting effective learning, memory and forgetfulness**
- **Thinking and reasoning**
- **Nature and type of thinking**
- **Problem solving and reasoning.**

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Unit IV

Observations

- **Attention and perception, factors affecting attention and observation and errors in perception.**

Unit V

Intelligence

- **Definition, individual differences in intelligence**
- **Mental ability and nature of intelligence**
- **Measurement of intelligence**
- **Development of intelligent behaviour.**

Unit VI

Personality

Meaning, Types, factors affecting development of personality

Characteristics of various age group: Child, Adolescent, Adult and Aged.

Will and Character.

Unit VI

Communication

- **Definition of Communication**
- **Purposes of Communication**
- **Process of Communication**
- **Barrier of Communication and establishment of successful Communication**
- **Types of Communication**
- **Importance and art of observing and listening in Communication.**

- Introduction
- History
- Meaning of Democracy
- Direct Democracy
- Indirect or Representative Democracy
- Condition Necessary for Democracy
- Indirect Democracy - An Appraisal
- Democracy in Asia and Africa
- Conclusion

Sir L. Namier in his book *CONFLICTS* says, 'Democracy implies political rights, irrespective of birth and wealth, and some agreed method of choosing and changing rulers, a power which, to be properly exercised, requires a reasonable nature of political liberty'. The three different aspects of social life and organisation covered by democracy are civic equality, self-government and freedom of thought.

Democracy transcends the West; its appeal is universal. The idea of freedom which is embodied in democracy seems to strike a sympathetic chord in the human heart. In terms of politics and institutions, democracy has at least five essential characteristics:

1. Equality under the law.
2. Equality of voting.
3. Periodic election of representatives.
4. Legislation by majority rule.
5. Freedom of political action and policy-making.

These are the rock-bottom features. There may be more to democracy – social welfare, for example – but there cannot ever be less.

Democracy expects a great deal from man. It requires patience and prudence and compassion and good will. It calls for, in addition another quality not easily come by, namely, civil alertness and an active desire for freedom. Altogether its attainment must always constitute a challenge to man.

Introduction

Democracy is difficult to define. It has never been easy to say with precision and inclusiveness what democracy is. Being essentially a humane polity, that is, one that is on the ideological plane rooted in ethics and justice, an understanding of it may lie in feelings as much as in reason. It is not a mere form of government. According to a political thinker, to say that democracy is only a form of government is like saying that home is more or less a geometrical arrangement of bricks and mortar, or that a church is a building with pews, pulpit and spire. Democracy is also defined as an attitude of mind of those who profess it, and only those who profess it can practise it. One may say that there are two general aspects to democracy: the political-institutional and the behavioural. On the behavioural level, democracy has wider applications. It is 'a way of life'. It is a way of looking at things. It is a way of feeling about humanity and society. It is a way of political behaviour. It is a way of acting toward one's fellow creatures and even toward one's own family. Consciously or unconsciously, the belief in and the practice of democracy affects one's whole behaviour, from everyday manners to life expectations.

History

The word itself is old; it was first used by the ancient Greeks in the fifth century B.C. It is, indeed, a Greek term, combining the two words 'demos', the people, and 'kratos', authority. The term 'democracy' made its historic appearance in the *History of Peoloponnesian War* when used by historian Thucydides (460-400B.C.) According to Thucydides, Pericles received of democracy as a form of government in which all people enjoy equality under the laws, with officials elected merit rather than on the basis of class, and based on the principle that the many are wiser than the few. But this democracy did not long survive. The strife and chaos of post-war Greece, which may or may not have been the result of ancient democratic practices, brought both the system and

+
Communication Skills

1300 Psychology is of interest to nurses because.

Its subject matter is that of human behaviour.

NURSES MEET PEOPLE EVERY MOMENT OF THEIR WORKING DAY.

The relationship with others into which nurses enter in the course of their work, make the job rewarding and interesting. Some of the people the nurse meets may behave in a manner which is difficult to understand. The nurse in turn needs to know her response.

Psychology seeks to understand why people behave, think and feel the way they do, individually and in groups, in all areas of life including health.

Psychologists not only seek to predict behaviour but also to change behaviours to enhance well-being

1340

Why study psychology?

Transferable skills.

Develop oral, visual and written communication, problem solving, memory and statistical skills, critical and creative thinking decision making, organization skills, team work and etc. skills

SPIRITUAL
WELLNESS.

Physical wellness.

SOUL
WELLNESS

SELF



Human Nature

ENVIRONMENTAL
Wellness

Emotional

Mental
Wellness

Wellness

Nursing is the diagnosis and treatment of human response to health problems: ANA

Emotional Intelligence -

Insolence.

Why Study Psychology?

Epidemiology means the study of disease distribution within a population.

Disease is the objective state of ill health, which may be verified by accepted criteria and canons of proof
Ex: microscopic analysis may yield evidence of changes

Mind is the subjective.

You cannot test conditions you - !

Schools of Psychology.

Cognitive - Humanistic - Behavioral - Psycho

Dynamic - Biological -

Biopsychologists are often accused of reductionism, which means that they reduce the person down to their biological components so explanations of human behavior are said to be due to anatomy or physiological changes such as chemical reactions in the nervous and endocrine system.

NBM

Nil by mouth

year 1

Sevent 1

9.7-04-2014

Biopsychology Identify biological causes for behaviour and individual differences such as:

① Genes ② Anatomical differences ③ Development

through the life span ④ Biological Systems such as:

1400 the nervous system, the endocrine system.

ENDOCRINE SYSTEM

Gland

Pineal

Regulates seasonal changes adaptively

Hypothalamus Regulates hormones at least indirectly

Pituitary produces a number of hormones - growth & dev

Thyroid metabolism and blood homeostasis

Adrenal metabolism and body hair, Hbly sugar and

Pancreas metabolism of sugar

Gonads stimulates the development of the sex characteristics

Stomach involved in digestive process

Heart Promotes salt loss in urine

The endocrine system is made up of glands that secrete

hormones into the body

1409 How each influences the behaviour of the person.

THE BIOMEDICAL MODEL

Suggests that the cause of illness were outside the control of the individual. all physical disorders can be explained by disturbances of physiological processes, which result from injury, biochemical imbalance, bacterial or viral infections and so on.

Psychology - little role in either health or illness and no relationship was postulated between the mind and physical illness (So called 'Cartesian Dualism').

BIO	MODEL OF DISEASE	SOCIAL
	PSYCHO	
VIRUSES	BEHAVIOUR	CLASS
BACTERIA	PSYCHICS	SEX
GENETICS	STRESS	ETHNICITY

The biopsychosocial model of disease

Behavioural change could be due to changes in the brain, endocrine, anatomical, genetic factors.

1460

- ⇒ Introduction
- ⇒ History
- ⇒ Meaning of Democracy
- ⇒ Direct Democracy
- ⇒ Indirect or Representative Democracy
- ⇒ Condition Necessary for Democracy
- ⇒ Indirect Democracy - An Appraisal
- ⇒ Democracy in Asia and Africa
- ⇒ Conclusion

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the word democracy into disrepute. Both Plato and Aristotle viewed it with disfavour. Plato, whose ideal polity was the planned state of Crete, referred to democracy as a 'charming form of government, full of variety and disorder, and dispensing a sort of equality to equals and unequals alike.' Aristotle, although he believed that democracies were likely to be more stable than oligarchies, questioned the wisdom of the principle of universal equality inherent in democracy, which he defined, in his *Politics* (Book IV), as "a government in the hands of men of low birth, no property, and vulgar employments." After Aristotle, democracy became identified with mob rule. Soon the term 'democracy' became discredited. Political thinkers concerned themselves primarily with such well-established categories such as monarchy and aristocracy.

Democracy came to be rejected on two grounds. Democracy was considered suitable only for a small country; it was inapplicable to large communities or big countries. The second reason for rejecting democracy was its identification with mob rule.

In England, democracy may be said to be slightly over a century old. In 1534, Henry VIII replaced the authoritarian Church of Rome with the no less authoritarian Church of England. But this formal transference of ecclesiastical power from Rome to London did not settle matters. The forces let loose by the Protestant Revolution could not and would not be contained by the traditional royal authority or by religious centralisation. Both were severely and stubbornly challenged by large segments of the English nation, including the Bible-reading middle class. For a century and a half, there was a wide-ranging struggle involving conflicting claims in the field of power and conscience—Parliament versus royal authority, Puritans versus the Established Church, dissenters versus other Protestants. The great conflict, which included a regicidal Civil War in the seventeenth century, ended decisively in 1689, with the proclamation of the Bill of Rights and the acknowledgement of the supremacy of Parliament.

William of Orange, the new Protestant monarch imported from Holland. Indirect democracy, found suitable for modern states with large populations, was developed in England in the seventeenth century. By 1850, the majority of nations had adopted democratic institutions. In Asia the seeds of democracy were sown when European imperialism was established.

Meaning of Democracy

Definitions of democracy are various. Dicey defines democracy as the form of government in which the governing body is a comparatively large fraction of the entire nation. Bryce accepts the definition that democracy denotes the form of government in which the ruling power of the State is largely vested in the members of the community as a whole. MacIver says, "Democracy is not a way of governing, whether by majority; or otherwise, but primarily a way of determining who shall govern and broadly, to what ends." This involves a freedom of choice in electing the rulers. It means that democracy has a popular base and it hinges upon the consent of the governed.

Democracy literally means "rule of the people", not the rule of the majority, for people means all the people, and, therefore, includes the minority as well as the majority. A system cannot be properly described as democratic if the majority has no share in the government. Many critics of democracy from Plato onwards have pointed out the danger of majority rule: if most men are ignorant, then democracy means the rule of the ignorant, which is bound to be bad. Democracy is a political doctrine, not a class doctrine, and politics has to do with opinions as well as material interests. An individual is sometimes a member of the majority, sometimes a member of the minority, and in opinion there is no permanent majority. Hence, in practice, democracy means the rule of whoever happens to constitute the majority on every issue or issues. Even so, the decision of the majority is not the method of democracy, since parliamentary democracy is the method of democracy, since parliamentary democracy is the method of democracy in Britain. By parliamentary democracy

is meant the method of debate or dialogue, "counting heads instead of breaking them", with spokesmen of the minority or minorities participating as well on equal terms. It is an important aspect of the democratic method that everyone takes part in the 'dialogue' which precedes the taking of decisions. In other words, democracy is government by discussion, or government by peaceful persuasion. In view of the above argument, it is preferable to define democracy in terms of its whole procedure, and to emphasise the principle of dialogue before the principle of numbers.

The first American President at the speech in Gettysburg encapsulated the essence of democracy when he defined it as the "government of the people, by the people and for the people". To this was added the resolve that it would not perish from the earth. Democracy is the government of the people because it has the support of the people who give it legitimate status. Elections make it possible for the people to elect their representative people's representatives. The irony is that even if the election is rigged those who form the government claim this legitimacy. True that the idea of government by the people, when superficially viewed, sounds preposterous, for in a democracy like India, the government cannot be run by millions of people. They cannot be expected to meet to make laws collectively as the people in the Greek city-states did over two thousand years ago. In a complex modern state the idea of government by the people is realised through representatives. In fact electorates do not anticipate the Greek style and are satisfied with such control over the activities of the government made possible by the representatives who belong to different political parties. Government for the people is government in the best interest of the people. However, the sad fact remains that there have been those representatives who ignored their responsibility to the people and used the mandate given them for self-aggrandizement.

Direct Democracy

In a direct democracy, the people themselves express their will on public affairs. They formulate and express their will in a mass meeting. In the small city-states of ancient Greece and Rome all adult male citizens were expected to meet together in the Assembly. Pure democracy has not been confined to the ancient world. Its surviving relics are found today in the Swiss "landsgemeinde" or popular legislature. Direct democracy can exist and function only in small states with a limited, homogeneous population where people can conveniently meet and deliberate together. In large complex societies, when the number of the people is too large and the area of the state is too extensive, direct democracy is impracticable.

Indirect or Representative Democracy

Indirect democracy is so called because citizens elect their representatives to govern on their behalf. Authority resides in the people, but it is exercised by the representatives. People elect their representatives for a term. The representatives, after the expiry of the term, report back to the electorate to seek a new term. People on their part have to determine if those representatives should continue for another term. This system ensures that there is harmony of purpose between the government and the governed. There is a tendency among people to form groups and to exert pressure on the elected representatives. This may be good in so far as it aims to convey their sentiments, but the practice should not get out of hand. Intelligent and well-meaning people devoted to the betterment of the people should be allowed to exercise their knowledge and analysis in an atmosphere of calm, and objectivity. In a modern state indirect democracy should have three main elements: the Electorate, the Parliament and the Executive.

Citizens qualified to elect their representatives form the electorate. Its size and scope are determined by law. Generally, the right to vote or franchise is not extended to minors and to those of unsound mind and foreigners. There is the view that there cannot be universal suffrage in the sense that franchise should be extended to all; franchise is not an inherent right of man but a sacred right of man which requires an informal exercise of judgement. The modern principle is that every adult man and woman, if not disqualified by the laws of the state, should exercise the right of voting. The creation of the electorate is perhaps the only way in which indirect democracy can be practised.

The Parliament or the legislature or the assembly is the most important organ of a democratic state, and the executive and the judiciary cannot function until the legislature has functioned. The Parliament has legislative and deliberative functions. It is a law-making body. The executive has a direct hand in the making of the laws. The cabinet discuss the proposal to introduce a bill on the initiation of a minister and if it is accepted by the Council of Ministers or the Cabinet, it is introduced in the Parliament. It is the duty of the minister concerned to pilot the bill through the deliberative process and see that it is finally passed. The Parliament is a forum where thinking is done and matters are debated. This deliberation is, in fact, at the heart of democratic polity.

All those officers of the government, whose business it is to put the laws passed by the legislature into practice form the **Executive**. But it is customary to use the term in a narrow sense to include only the Chief Executive Head of the State and his advisers and ministers. The policies and programmes implemented by the permanent civil service. In its broader sense, the executive includes the civil service concerned with the work of administration. Each department of administration is headed by a minister who ensures that his department

pursue a definite policy and direction. The members of the civil service are not involved in party policies. Their knowledge and experience help the minister to shape policies.

Administration of justice is the function of the **Judiciary**. It guards the rights of the individual citizen and protects these rights from encroachments. The fact that prompt administration of justice prevails not only ensures his liberty but also maximises it. Courts are agencies for the decision of disputes between individuals and between individuals and the state, and for the trial of persons accused of crime. Courts perform various other functions. Courts participate in the determination of law. They prevent infractions of law and the violation of rights. In a democracy, the judiciary is independent; it cannot be influenced by the executive. The independence of the judiciary is essential to uphold the rights of the people and to protect the minorities against the tyranny of the majority.

One of the most fundamental characteristics of democracy is the **Rule of Law**. First, by the Rule of Law, it is meant that no man can be punished or lawfully made to suffer except for a distinct breach of the law established in a legal manner before the ordinary courts of the land. Secondly, it means not only no man however important is above the law but that every man is subject to the ordinary law of the land.

Conditions Necessary for Democracy

For democracy to prevail certain conditions are necessary. People should have the democratic will. They should be conscious of their rights and their responsibilities. They should be capable of rational conduct and must participate fully in the affairs of the state. They should have the courage to criticise the government, for "to articulate is its very life; to numb its demise". Democracy also involves fellowship, a feeling of fraternity so that the common aim of the welfare of the state could be achieved. Society should be one of equals and should not be divided on the basis of religion, birth or wealth. The absence of harmony ensures equality of opportunity and social justice. Since democracy is the rule of the majority,

there should be tolerance; the interests of the minority or minorities should not be disregarded. The minority should not be at loggerheads with the majority; there should prevail a sense of give and take.

In a democracy there should be opportunities for the development of individual personality. Everyone should have access to knowledge, education, etc. Participation in democracy involves the sharing of responsibilities. Active, intelligent and effective participation is possible only if the citizens are adequately educated.

Indirect Democracy - An Appraisal

Man has lived for about a quarter-million years on this planet, yet he has had some knowledge of democratic ideas and practice for only about twenty five hundred years. Even today, democracy as a way of life exists only in a small number of countries. Only about one in four practises its basic procedures. Of the many democracies which have been born in the past, only a handful have survived. In the past years the casualties have been peculiarly heavy among the former dependencies of the West for the simple reason that these were countries which were currently embarking on democratic experiments. The fragile mechanism of representative democracy which almost all of them adopted proved shortly to be unfitted to the needs and capabilities of most of them.

As a concept, democracy can best be understood as having not just one but three interrelated meanings. First, and most important, it is a way of making decisions. Second, it is a set of principles by which those decisions are made. Third, it offers a set of normative values. A Greek text summarises the basis on which democracy makes its decisions. The Greek term *demos kratos* means simply people power. Probably not very long after this term was in common use, Pericles, leader of Athens, when it was the model democracy among the Greek cities, could say, "We are calling a democracy because the government is in the hands of

many, not the few." This definition of democracy has remained remarkably consistent throughout history. Over two thousand years later, the great French political theorist, de Montesquieu, who so strongly influenced the thinking of the American founding fathers, echoed the ideas of Pericles, "When the body of the people is possessed of the supreme power, it is called a democracy." And, of course, best known to Americans, is Abraham Lincoln's famous description of democracy as government of the people, by the people, and for the people." But in spite of the seeming consistency of the words which have been used throughout history to describe democracy, the term has had a very different meaning at various times and places. Nothing would seem to be simpler, for example, than to say that democracy means 'people power'. But immediately two vital questions demand two answers. The first of these is; What does **people** mean? The other is: How is this power to be organised and exercised? The history of democracy for more than two thousand years has been little more than the story of the various efforts to give satisfactory answers to these two questions. There is thus much confusion and misunderstanding about the meaning of democracy. George Bernard Shaw once proposed that, in order to eradicate the confusion about the meaning of democracy, the leading scholars and thinkers of the world be convened and the issue settled once and for all.

If democracy is a regime in which those who govern are selected by the governed, the situation is altered by the development of parties, and these parties often hinder the democratic process and the system becomes far removed from the spirit of indirect democracy. People vote for a party, and a representative elected by virtue of his party membership assumes responsibility to the party. Representation becomes party democracy. Democracy is also criticised on the ground that it hampers the growth of classes. When men of fame and fortune are elected, they may be inclined to favour their class rather than the community as a whole.

However, democracy has endowed mankind with many advantages. The primacy of the laws of the country is assured, and the sphere of private life will not be invaded except by the due process of law. Democracy continues to spread. The concept of democracy appeals to people. The citizens' consciousness of their rights and responsibilities makes them active participants in the affairs of the state. Democracy ensures the twin principles of equality and liberty. It allows the development of human capacities. It stimulates the interests and energies of all and the prosperity achieved is widely diffused. Democracy precludes revolutions, for people are sovereign and subjects, and the existing government can be removed by peaceful means.

Democracy in Asia and Africa

Among the non-European peoples, the former colonies of the West made the nearest approach to democracy, despite the serious defections later. The faith of their leaders in democracy was shown at the outset in the style of constitution which they created. In a few countries, headed by India, the constitutions have so far maintained themselves as living realities. It must also be recorded that there was protest against the assumption that Western-style parliamentary institutions are appropriate for non-European peoples. Among the former colonies there has been a shift away from democracy. 1958 was the year of the great collapse. Within a few weeks of each other, Pakistan, Burma, and the Sudan surrendered the civilian governments into the hands of the military who, varying degrees, abrogated constitutions, postponed elections and abolished or sidetracked political parties.

Independence in these countries meant enfranchisement of large numbers of people. Their expectations were aroused and they hoped for quick economic benefits. Democracy failed to produce results with adequate speed, if the politicians who manipulated the machinery came to be seen as self-interested and corrupt, the masses could

not be counted on to rise to the defence of an unfamiliar political system. The people at large lacked the democratic tradition. In many instances, it is probable that the people felt more at home with a government which told them what to do than one in which they had to exercise the freedom of choice.

There was the tendency to exclude the masses from any effective share in political life. There developed among the nationalist elites a "Messiah" complex by which they could justify any deviation from democratic principles. Nationalist parties and movements came to be built around dominant personalities rather than on programmes or ideologies. This centralisation of loyalties may be attributed to the lack of political experience and sophistication of the masses. There is the age-old assumption that the few at the top were the masters of the people and the custodians of power.

Conclusion

There seems to be no general agreement regarding the appropriate form of democracy. Even certain communist parties claim to be democratic. Carl Marx claimed that the West was characterised by competition among political parties which to him was a feud between classes, the believed true democracy will exist only when one class eliminates the overwhelming masses. A Norwegian political party has counted about 300 types of democracy. Today, democracy is associated with progress. No form of government is a panacea for all human ills. In comparison with the experiments of the past, democracy has justified itself.

Democracy is one of the rare types of government instituted for the purpose of reducing inhumanity and raising hope. It recognizes the dignity of the human being, guarantees the equality of the individual. It gives attention to individualism and helps to create an open society that provides political, social and economic facilities for the masses.



1313

2024

2014

Biological - 1

Psychodynamic - 2

Behavioural - 3

Cognitive - 4

Humanistic - 5

Our behaviour is explained by the different items. Alzheimer's person has changes in the cells of the nervous system. Genetic differences predisposes to some diseases. Learning disabilities persons - Biological.

3

13.26

Psychodynamics of Freud's model. The elements of the Id, ego, and superego. The Id is the biological and psychological drives that a person is born with that constitute the Id.

The ego is the component of the personality that mediates the drives of the id with reality, in a way that promotes well-being and survival. This

The Superego it is often referred to as the conscience of the person,

What is metanursing {METANURSING}?

1313

2024

2014

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What is metanursing {METANURSING}?

CHOTANB

NURS1007

What is globalisation?

5

A Little History

In March 1952, Harry Markowitz, a 25 year old graduate student from the University of Chicago, published Portfolio Selection in the Journal of Finance. The paper opens with: The process of selecting a portfolio may be divided into two stages. The first stage starts with observation and experience and ends with beliefs about the future performances of available securities. The second stage starts with the relevant beliefs about future performances and ends with the choice of portfolio. Thirty eight years later, this paper would earn him a Nobel Prize in Economic Sciences.

Two basic elements of investments:

the investment opportunity;

the investor.

Our task for this class:

a model for financial assets;

a model for investors;

optimal portfolio selection.

One measure of the attractiveness of a portfolio is its Sharpe Ratio (S)

MAJOR SCHOOL OF THOUGHTS -

Psychology

1334

The structural relationship formed by the id,

ego and superego is the accumulation of societal norms

and personal values as interpreted by individuals.

The superego emphasizes not reality, but the ideal, and

its goal is perfection, as opposed

S Freud (1931)

The Bandura Theory -

THE PRECONSCIOUS, THE CONSCIOUS, THE UNCONSCIOUS

CIONS

It has been suggested that stages - most important

is the phallic stage - experiencing the Oedipus or

Electra complex.

1433

Semester 1

YEAR 1

Roles of Nurses (Exam No 1)

Teacher (educator) → will teach the patient about the illness, about the medication, or treatment (learn about health)

* Counselor → help the pt to cope and recognize a stressful psychologically

Compassion →

Respective → Respect the pt belief (Custom), emotion

Advocacy → reporting for a doctor

Manager → manage the care of the pt.
individual, family

Leader - encourages others to work within a team.

Practitioner → completed the qualification.

> The nurse is a member of the multidisciplinary team.
(Doctor, pharmacist, dietician, ...)

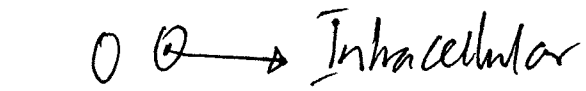
Communicator → Communicate with the pt in a polite way.

> The nurse role, a model for other, must be qualified, good behaviour.

2014

2504

0937




Intervascular (between veins) space
Live red cells - red - dead red cells - blue

Third space - Joint - subarachnoid

Space -

head of baby $\frac{1}{3}$ of body - CSF - Serum

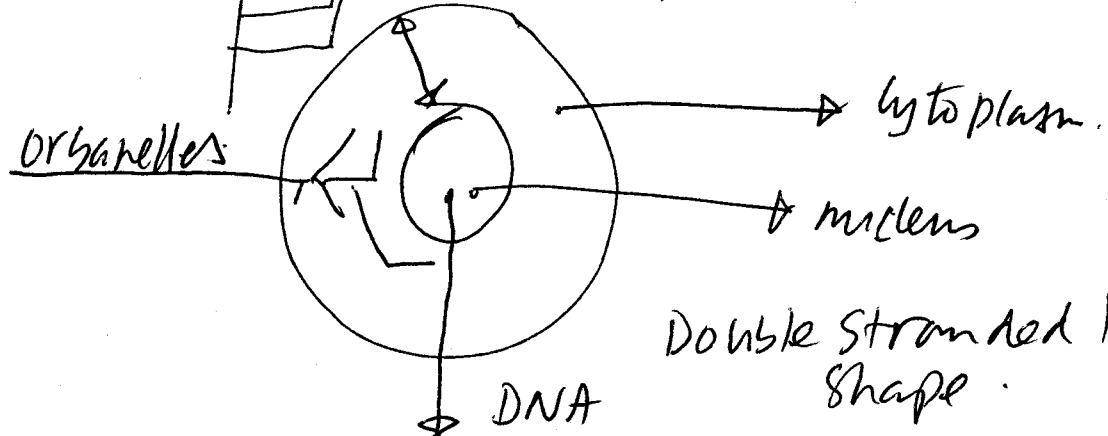
$\frac{1}{3}$ fluid - space between - fluid moves between compartments.

Plasma membrane: forms the outer boundary of cell - Electrolyte balance, Homeostasis - Intercellular & extracellular

Cellular organelles: each - endoplasmic, golgi -

Ribosome, lysosome, mitochondria, Centriole

Endoplasmic Reticulum,



10/10

10 Semester

YEAR 1

2014

2504

1015

72 Hons.

Functions of each organelles.

life span of sperm -

Cells function.

1 Metabolizes and releases energy -

• Chemical reaction that occur within cells.

• Release of energy in the form of heat help ^{Maintain} ^{Temp.}

2 Synthesizes

Cells differ from each other because they
synthesize different kinds of molecules.

3 Provide a means of communication

achieved by chemical & electrical signaling

Cell reproduction

mitosis - / meiosis

Cell membrane - ^{selective} permeability - osmosis

Blood brain barrier - Allergy -

Allergies - asthma, Rashes - An Allergy.

Response - on activation - marks cells

Histamines $\rightarrow$ cells $\rightarrow$ blood vessels walls $\rightarrow$ Impair permeability function - rashes - Anti-histamines -PHOSPHOLIPIDS
Double layer of ^{phosphate} ^{lipids} ^{Barriers}
a head & tail

10-25

7nm

NURS1002

2014
2504
1030

Cell mem (+ cholesterol + glycolipids)
Scattered proteins

Head > hydrophilic - + water

Tail > hydrophobic - water

Cholesterol bind mem. cell in membrane

Fat soluble vitamins, oil soluble vitamins -

1 capsule

Enriched

2

O Hydrophilic

3

CH₂OH

4 Transport Diffusion

CH₂OH

5 Transport osmosis

hydrophobic

O

hydrophilic

Thursday - 31 - Transport -

NURS1002 (A).

Section 1

Information
w/

Teacher
10 min -
Summary

Q&A
End of Term
Exam

MCQ
Short answer
5

Short answer

Group work 20 min

Assignment 20% of mark

Written 25% of mark

Lab 30 marks

Q&A

Summative Test

10 min

Random

2
End of term

2
Interpreters

Section 2

Life Sciences ①

Introductory

Anatomy & Physiology

Rules 1: If it involves individual person

in class - respective committee -

2: anyone - Bryan.

3:

Let's start

1

OBJECTIVES - must know -

Anticardiac - receptors -

Oedema - fluids regulation

Thursday left

Define - Anatomy and physiology -

levels organization at basic characteristics of life.

Define - Anatomical position

Define directional terms and relationship

Define body parts to one another

Define abdominal region -

Discuss axial and appendicular
to body status

REGULATE body functions

BMAE60

THURS

FRID

LAB

WEB

Resource

BRYAN

B.A.MSC

MOD -

MED -

SUR -

Epidermal

ADIPON

Emi -

mar

Unison app

Mr Bryan

Bryan

MOD -

FRID

MARK

NURS1002

What is globalisation?

PRYMO

The process by which businesses and other organisations develop international influence or start operating on an international scale: fears about the increasing globalisation of the world economy. Q1

Illustration
McDonald's International Changes way people shop Create Dependencies
Engen Petroleum Industry

Benefit 1: Globalization is not a new trend in which one party dominates and assimilates another but an ancient and neutral process that affects all parties equally. Food is intertwined with culture. We plan to frame the case by emphasizing the complex role food plays in culture. The primary example on which we will focus our discussion will be coffee. This example will highlight the integral role food and drinks have shaped social, intellectual parts of speech in a culture.

As well as comprehending the history, it is also valuable to weigh the advantages and disadvantages globalization has had on the food product. Sometimes, an aspect may be neither good nor bad. Once again, through analyzing these two examples, general conclusions about globalization and food can be made. Throughout history, globalization has greatly impacted the food of many different cultures. One of the conclusions that can be drawn is that globalization can not be classified as something wholly good or bad, but rather a phenomenon that has revolutionized both food and culture.

Drawback: Globalization is not a one-sided relationship. Many opponents to globalization believe it to be such in which the dominant side imposes its culture on the weaker culture and destroys it.

Benefit 2: Actually, globalization mingles the two cultures to create something completely new. Furthermore, with this culture exchange comes fusion food. Because of the many Asian immigrants to the US, Asian American fusion food has developed such as Chinese Chicken Salad or Thai Pizza. Hence, globalization benefits and changes both sides in the exchange.

BRAND STORYMATHS

ANATOMY

VLS

Physiology

?

axial and appendicular -

MORPHOLOGY

ANATOMY & VLS

The body parts and its relation to each other -
A specialized body, step by step, - Beyond part -
and what is common in the part -

Physiology involves the function &

Body modules clothing function -
live -

Heart pericardium, myocardium, endocardium.

Apex - in the heart - tip of the H -

anatomy in hand with physiology - 206 Bones.

600 muscles of the body - 12 function

Semester 1

Lr1

NURS 102

CHARACTERISTICS OF L 3.

BRVW

like
sharles

MOVEMENT - self-initiated

self-initiated -
movement

change in position, motion of
internal part

RESPONSES AND - instantly - Ability to sense

changes within, or around to again and react to them.

GROWTH

Increase in body size

Reproduction
modulus of response

Respiration
Obtaining O₂

Digestion
chemically

Absorption

comatose patients # Smooth muscles.

Allosteric - react - brain stimulation -

intensity, intensity, response - response -

- we grow - hormones. At thyroid - grow -

Growth hormone, pituitary gland - let on bone -

in length or width - gigantism -

to reproduce - procreate - copulations - Sperm -

head-tail - sperm analysis - morphology

count - every cube with 10m Sperm -

head - and tails -

September 1

RLI

Byly AW
1704.187

Number 002

2

What is globalization? \ 50

⑬

Sources to Use Wilk, Richard. Fast food/slow food: the cultural economy of the global food system. Lanham, MD: Altamira Press, 2006. Food Policy. Guildford, England: IPC Science and Technology Press, 1975-present. Pingali, Prabhu. "Westernization of Asian diets and the transformation of food systems: Implications for research and policy." Food Policy 32.3 (2007): 281-298. Web. 21 Nov 2009. Roe, Sue. The private lives of the impressionists. New York, New York, 1st ed. Topix, Steven. "Coffee and Globalization." Cultural Critique 71 (2009): 81-106. Web. 21 Nov 2009.

09/10

menstruation 12-20 - lftan -

not ovulate $\equiv$ hormonal menstuation -

Retio
nchsm

the ovary 1 year $\equiv$ sexual immaturity -

Digestion -

Absorption - Passes digest product

(food water) through membranes and.

into blood - mitochondria of power house.

O_2 - nutrients - Cardiac arrest - O_2

Kidney stops - die - Brain do not use CO_2

muscles use carbon dioxide -

09/15

Remnant - in lungs - in cells - breathe -

in - 72 hrs - lactic acid is not elevated -

lactic $\uparrow$ when CO_2 - No elevation of lactic acid -

Lactic - pain, fatigue - muscles use CO_2 -

09/19 - know nutrients - absorb - and excretion -

15 min Breake - organelle RTF.

Genetics 1

⑭

Year 1

Basal
Life
Style

Absorption - Intima. Vascular System
Luminal lumen - food absorp - goes to
circulatory ad system for distribution.

(circulation - movement of
substances throughout the body.

Assimilation - changing absorbed
substances into chemically different substances.

Excretion - Removal of wastes

Metabolism - All physical ad.

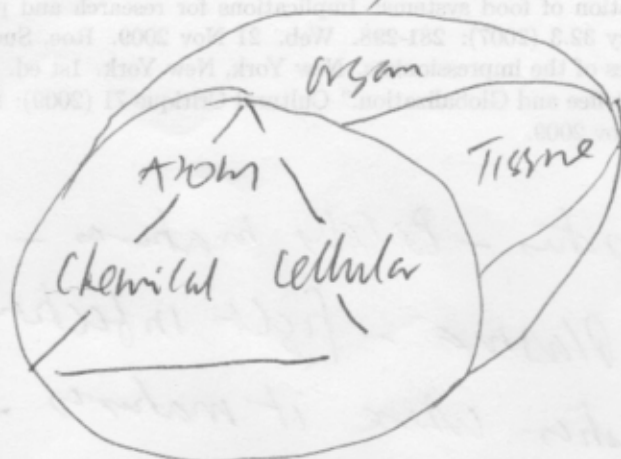
Chemical changes occurring in a
person

- 1. Move
- 2. Digest
- 3. Senses
- 4. Grow
- 5. Reproduce - sex cells
- 6. Excrete
- 7. Intake

Level of organisation

Mlesse

Q53 Cell-Basic functional unit of the organism
(Chemical - microscopic - gross - level) -



- Squamous cell carcinoma - Disease.

process -

- HIV - Sterile environment - B cells drops -

Soo Nond - D - B cells helps - measured
by blood test -

Human immune deficiency virus - HIV -

apronym -

AID = HIV + infections + secondary -

Autoimmune disease -

All patients are HIV - needle needle, precautions

NURS1002.

Nursing Notes

000.B.S.Fatally

Anatomy

α.

Physiology -

(19)

14 Apr 2014 10:17 p.m.

BRVAN

No 2

Google -

Type

Level

is

Structure

agreed

2

What is globalisation? \ \$0

Sources to Use Wilk, Richard. Fast food/slow food: the cultural economy of the global food system. Lanham, MD: Altamira Press, 2006. Food Policy. Guildford, England: IPC Science and Technology Press, 1975-present Pingali, Prabhu. "Westernization of Asian diets and the transformation of food systems: Implications for research and policy." Food Policy 32.3 (2007): 281-298. Web. 21 Nov 2009. Roe, Sue. The private lives of the impressionists. New York, New York. 1st ed. Topik, Steven. "Coffee and Globalization." Cultural Critique 71 (2009): 81-106. Web. 21 Nov 2009.

Lymphatics - B Cells matures - Immuno -

Globulin, & Syn Plasma - fight infection - proteins

10/14 goes to lymphatics where it matures - Varicella -

develop antibodies - body produce to ant agent

Varicella = mother exposure - antibody

ready - Antibody goes to lymphatics ready

for proliferation - Area where antibodies get

matures - submandibular lymph nodes - upper

axillary nodes - deep - physical exam -

to palpate lymphatic nodes - infection control -

① Immune. ② regulates fluids ③ blood vessels.

+ lymph vessels - nodes - BY lymphatics

Capture fluids - return it to LV circulation -

Fluid regulation -

Semester 1

17-04-14

Year 1

NURS1002.

Basic

Life

Share

1010 -

Anatomy
&

Physiology

Organs systems the human body -
lungs - bronchi - bronchioles

Respiratory

COPD

COPD - Chronic obstructive pulmonary disease -
Smoking - ICU - Respirator - O₂ therapy -

O₂ therapy -

Digestive system - Stomach - esophagus

Stomach - intestines, pancreas, gall bladder -

Small intestines - Ileum - Jejunum - Cecum -

Colon - Sigmoid -

Absorption of food - breaking down -

Saliva - enzymes - amylase - starch - carbohydrates

Carbohydrates start at mouth - amylase - enzyme -

next - starts at stomach -

Endothelium - regulates temperature - protection of

Heart, Insulin - Hormone of water & salt -

Cholesterol - pressure - fat - End -

Skin - protection - first line of defense - Intact skin -

1036 Temperature - Esthetics -

metabolism & heat - the shivering - brown fat & O₂

Search 1

17-04-2024

Year 1

Life
Science

Protect - blood production - erythrocytes.

What is globalisation?

man - calcium bank - 1.5 kg³ calcium.

Globalization and immigration have gone hand-in-hand: each has greatly benefited from the other. Laborers still move around to look for a better life, and sex trafficking still exists; globalization has just made it easier and faster for these migrant workers to move around.

Globalisation influences global culture (the metaphorical melting pot of cultures) through human interaction (food, business, trade, crimes).

Globalization has increased and or decreased the presence of mixed races in Mauritius.

Transportation, Globalization, and Widespread Havoc

Size of the body -

150

Muscular system - 600 muscles - 300 muscles

function - movement - contracting, relaxing, 206 bones.

bank of proteins - uses all issues - use
make them bigger - protein - digests to

Kidney - Bone proteins are large molecules

1046. how to go to kidney -

Nervous system - impulses - co-ordination -

CNS - PNS - CNS - Brain & spinal cord

ANS - others - spinal nerves, cranial nerves -

Brain - cranial nerves, - spinal & spinal nerves Learning to

Brain impulses the body to walk -

walking different in 1 year old & 10 year old = Walker

Learning to walk - cerebellum tells angles

1058 the position of the legs -

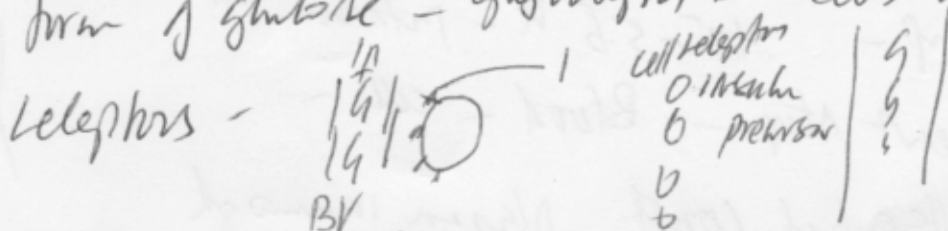
Basic

Life

Science

Endocrine produces hormones —

Adrenaline — insulin — Normal glucose level —
 Glycogenesis — formation of — glycogen stored
 form of glucose — glycolysis — Cells have



The cells needs ^{BV} ~~insulin~~ —

The glucose in the blood increases, the
 brain tells the pancreas to produce insulin —
 The insulin binds the cells by receptors act as
 a precursor to allow the glucose to get into
 the cells #

A transport protein that requires a precursor

11:26

Pituitary ————— ketone/uric.

Cardiovascular system — it transports

NURS1002

Anatomy & Physiology

BRYAN

Nursing Notes

10.

14 Apr 2014 10:17 p.m.

No 4

Basic
Life
Science

Cardio Vascular System

4 Potassium - mixed for heart
What is globalisation? \$0

FDI

Investing in local businesses by foreign citizens often involves stock ownership of the business.

1129.

dup - 4.5 - 5.5 K^+ potassium 4.

heart stop - Blood - cells -

Differential count, plasma immunoglob

urinary system - Dialysis fistula -

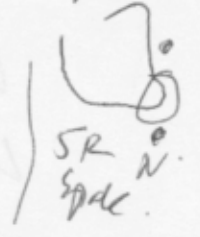
Subclavian vein, support - 2wk -

Ven + artery anastomosis - kidneys -

1147.

Reproductive System -

Cardio
megals -
Apex.

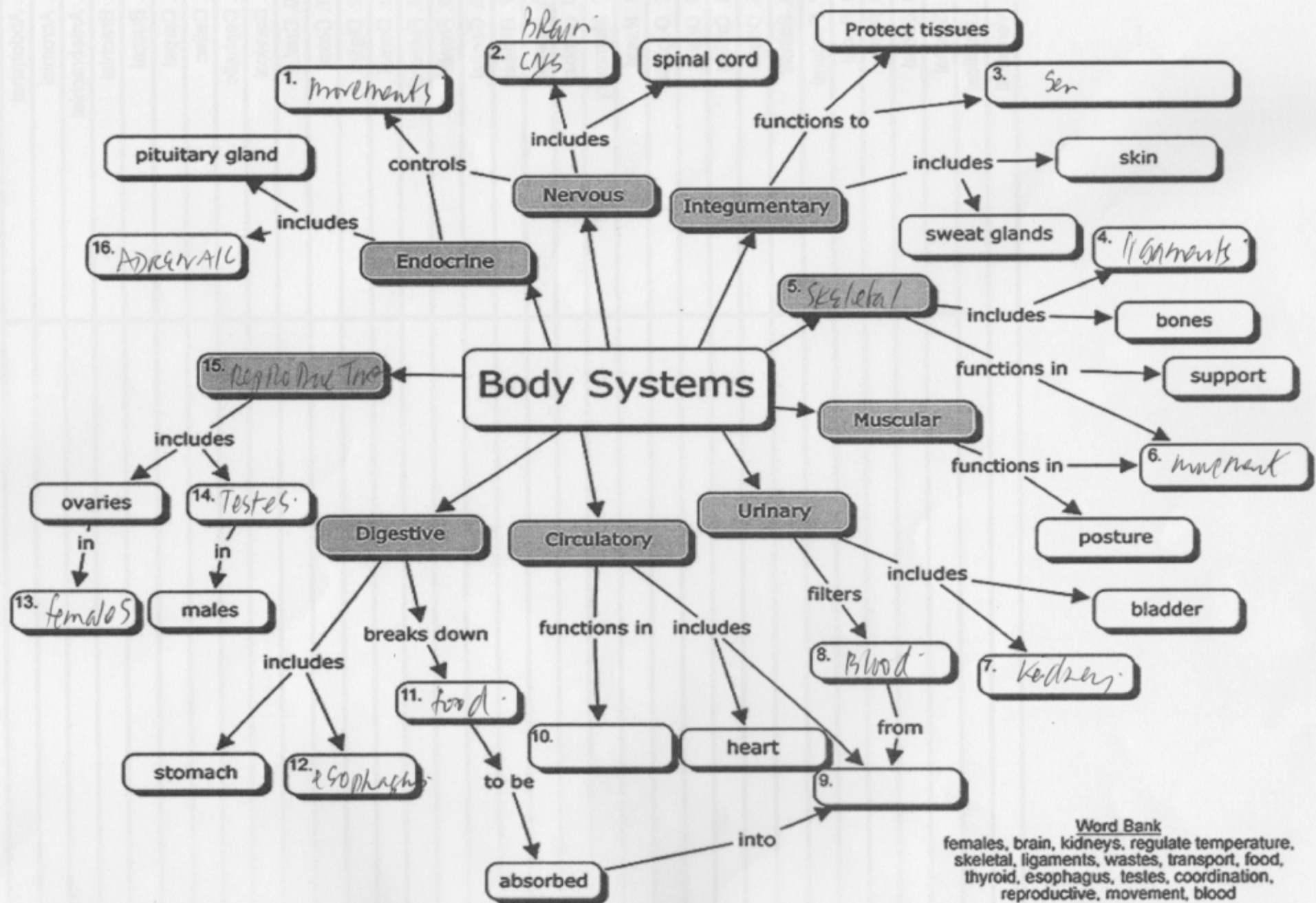


Summary
for
Tommorow

Name _____

Describe the body region each of these terms refer to:

1. Abdominal	
2. Acromial	
3. Antebrachial	
4. Brachial	
5. Buccal	
6. Carpal	
7. Celiac	
8. Cephalic	
9. Cervical	
10. Costal	
11. Coxal	
12. Digital	
13. Dorsal	
14. Femoral	
15. Frontal	
16. Genital	
17. Gluteal	
18. Inguinal	
19. Lumbar	
20. Mammary	
21. Nasal	
22. Occipital	
23. Oral	
24. Orbital	
25. Otic	
26. Palmar	
27. Pectoral	
28. Pedal	
29. Pelvic	
30. Sacral	
31. Sternal	
32. Umbilical	
33. Vertebral	



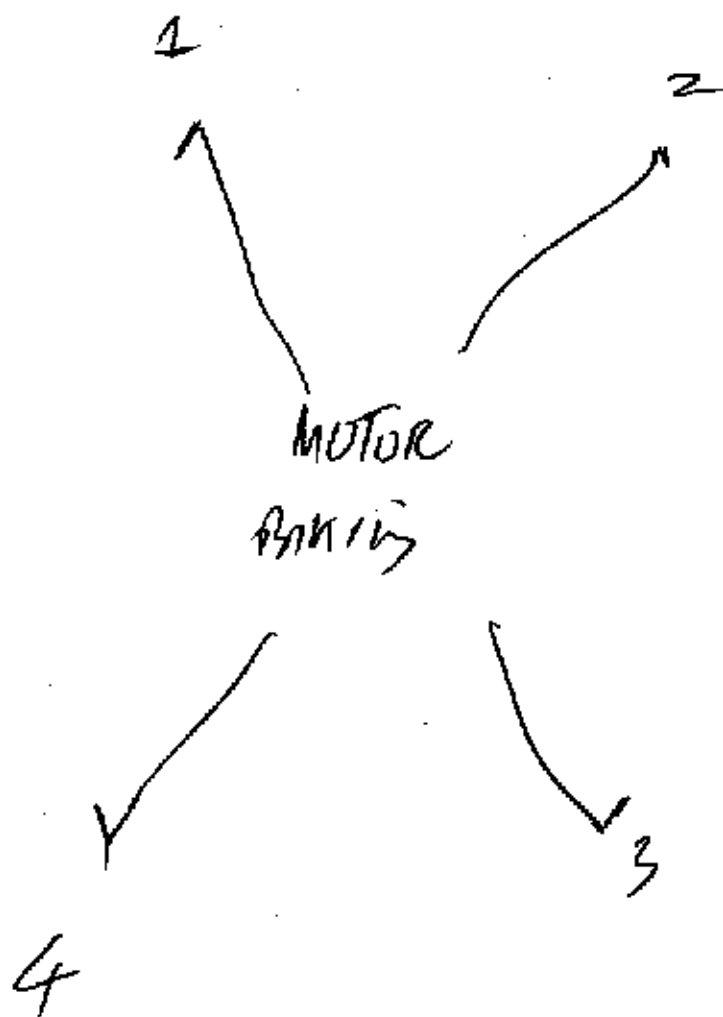
Word Bank
 females, brain, kidneys, regulate temperature, skeletal, ligaments, wastes, transport, food, thyroid, esophagus, testes, coordination, reproductive, movement, blood

NUTS 1002

Summary
NUTS 1002

Prima
hood
redgrrs

0800



Balancing the odds of ~~sp~~ game betting

VIRGIL FOX

Semester 2

18th APRIL 2014

YEARS

18-414

is the existence and maintenance of a relatively constant environment within the body.

Input:
Information sent
along afferent
pathways.

Control
Centre

Receptor (Sensor)

Effector



Hypothalamus

Change
detected by body

Stimulus
produces
in
Variation

Variable

Imbalance

Blood
 $H_2O \rightarrow$
12-16 g/dl
 $\rightarrow O_2$ 95%-
100%
pH
percentage
hydrogen
Na - 65-105

Lapse of
effect
feed

(Disorder - fails to maintain homeostasis)

Na $\rightarrow$ pH $\rightarrow$ O_2 $\rightarrow$ H_2O

45-105	7.35-7.45	15-100	12-16 g/dl
g/L			mg/dl
	Range		

{ front - brain - kidneys } = steroids
Schwartz 1 antibodies - others.

Year 1

NOR4002

Life Sciences

Prima

18-4-14. The body with by a homeostasis

The body falls to maintain

pH & bicarbonate -

Na⁺ & Sodium bicarbonate

2: Hyperoxigenate damage retina -

Hyperoxigen

Hyperbaric chamber 100% Oxygen in chamber

O₂ ↓ 89% - (N 95% - 100)

O₂ solubility
partial O₂ small
partial O₂ small
NA

1: Receptors - Chemore - Chemical - medulla
Stretch - O₂ sensor

O₂ receptors - Kidneys, blood vessels walls -

Cardiac - Lungs → O₂ %

Medulla
O₂ sensor

Respiratory rate

O₂ receptors

90%

Kidneys - 10% O₂

Haematopoietic
factor

Year 1

Contract

Contract
blood vessel

Lungs
Receptor

0855 Haemo
globin

Erythrocyte
production

Bone
marrow

Scheme 1

NURS1002

12474

13(4)

Body A

TEMPERATURE.

36.5 - 37.5 C

Range

Kinases
O₂
receptor

parathyroids
= Nervous fibres

attendant

Thermoreceptors
all over the body
detect 90 C

Logarithmic
0.004

Negative

Positive

Feedback

Feed back loop

Hypothalamus
Thermoregulator

Log

T °C

38.0 C

Hot
Mod
Thurs
5"

NF Normal 37.5 C

Cells to dilate
vessels
Red-flushing

INTERMEDIATE

skin

Sweating
vasodilation
w/te evapori

T °C

+ = Do not live
with blanket

Lungs
K °C

RTR Sparging

Kinases heat
ventilation.

NFML

is the mechanism of maintaining re.

State homeostasis by resisting a deviating changes
in the normal value.

Negative Feedback loop. NFBLM

Semester 2

RECEPTOR

Year 1

Positive feed back mechanism
PFBM

Starts continues never stop -

implies that when there is deviation from
normal range, the response of the system is to make

① clothes DFML deviation/larger
mechanism

② Breast feeds DFML -

③ Nursing is like DFML.

Positive feedback mechanism created.

" Vicious cycle " leading away from homeostasis
that might lead to death.

① turns ② clothing factors - DFML 12 cycles

1-1 15 mins per group -

- Group # # Dress #

0146

TERMINOLOGY

and

BODY PLANES

□ Anatomical Terms

□ Body Planes

□ Body Regions

> Appendicular and Axial

> Abdominal Regions

> Body Surface

> Body Surface Regions

□ Body Cavities

> Ventral Cavities

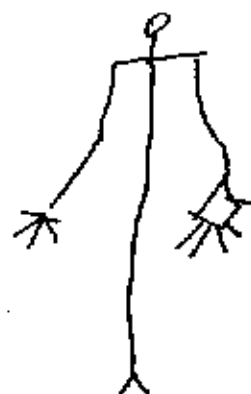
>

DIRECTIONAL TERMS = refers to

Relationship between wrist to elbow

Refers to the body in anatomical position regardless

of actual position



Anatomical Position Peral Shaft -

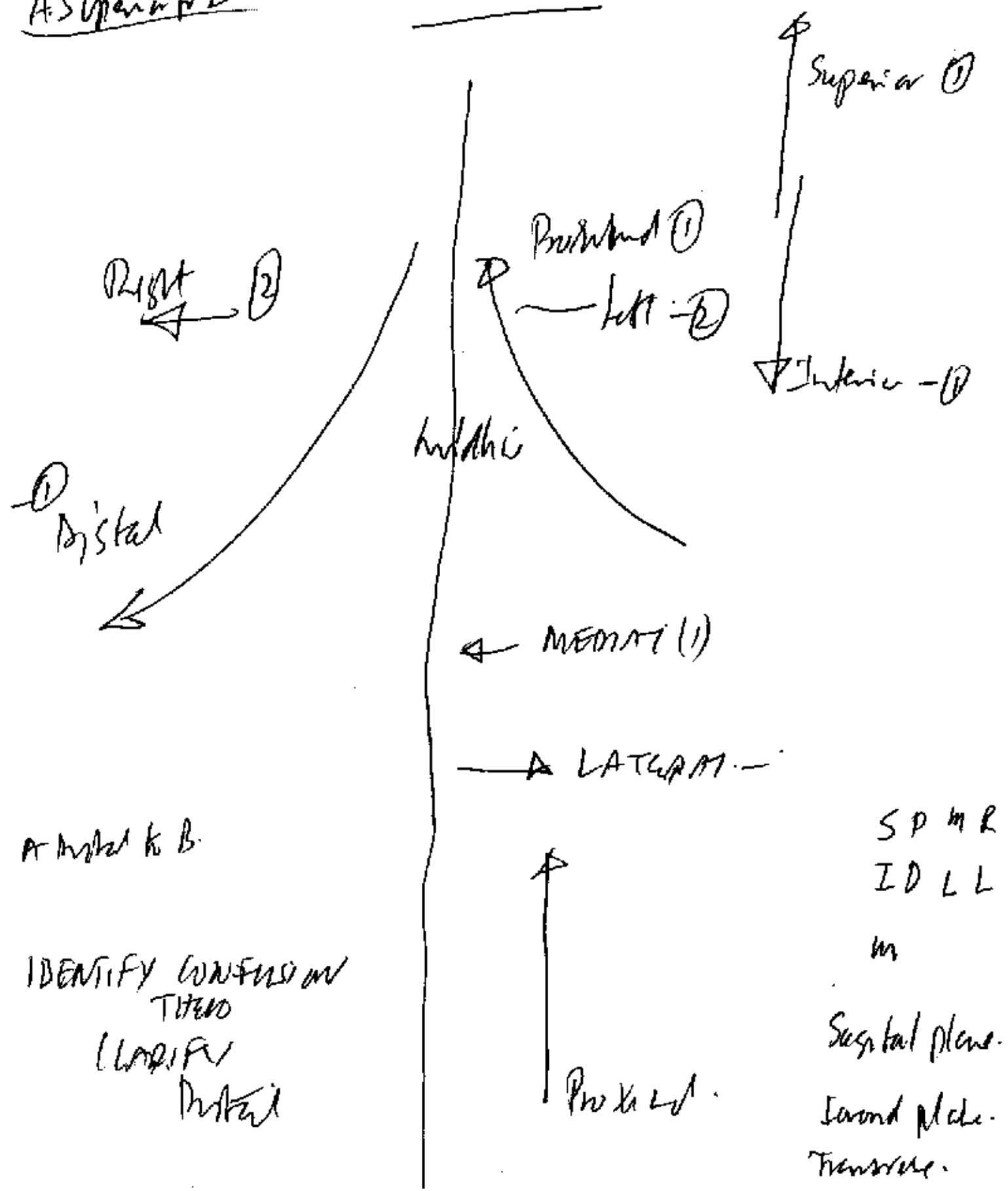
Refers to a person standing erect with feet forward, arms hanging by sides and the palms facing forward - Recall.

Rev 2/10/02

⑨

Directional Terms

A Superior to B



A medial to B

IDENTIFY CONFUSION
THIRD
(LATERAL)
Distal

Dorsal Ventral

SPMR
IDLL
m

Sagittal plane.
Coronal plane.
Transverse.

Method to
18-4-2014

A medial to B

Nmms 1002

(18)
Anterior = Ventral.

Proxim = Dorsal -
Posterior = Dorsal -

1004.

BRNA

Superior



Inferior

= Anterior
= (Ventral)

Posterior =
Dorsal =

Proximal
Distal

A is x to B

B is x to A.

The word is anteroposterior Dorsal.

Semester 1

18-42014

Year 1

NURS1002

④ 11 Distinguishing Anatomy

Proximal & Distal w/ idiosyncratic
extremities.

Point of attachment. Shoulder - first

pubic for
limit description, like the left, upper. bone.
Compare - description for arm

BLVAT -
Superficial - deep

epidermis

dermis

fascia

muscle

bone

Proximal

Distal - further

Proximal

Proximal - nearer

right upper

right lower

left lower

Point of

Reference.

1. Lateral away from midline

2. Superficial - deep +

→ towards the

surface

medial towards the middle of the body

the body -

18-4-2014

Semester

Year 1



Nov 10 2 -

(12)

week 2

Cells &
Tubules
—

Ureters
Guan li
& Santals
—

1129

○

Planes -

A Sagittal plane that runs

through the body and separates it in Left & Right parts

and sagittal

Transverse Transverse or horizontal plane

11/14 MRI 64 planes set Sagittal

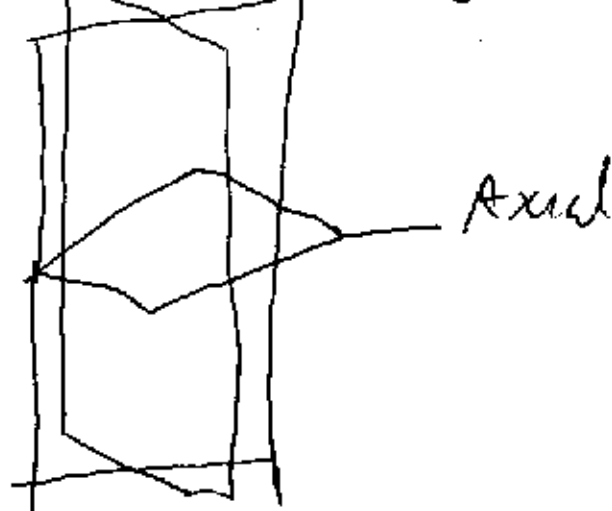
18° Plan.

Plane

and sagittal equal half RT & Lt.

Superior Transverse, inferior transverse view.

Coronal with Sagittal.



Numb 1002
Licksheres.

DIRECTIONAL TERMS

distal

1. The fingers are distal to the wrist.

1A The hand is distal to the elbow.

proximal

2 The elbow is proximal to wrist

2a The wrist is proximal to the fingers.

3 The head is superior to the chest.

superior

3a The neck is superior to the ribs.

4 The kidneys are lateral to the spine

lateral

4a The lungs are medial to the ribs.

medial

5 The nose is anterior to the throat

anterior

5a The tongue is posterior to the teeth.

posterior

6 The navel is superficial to the ribs

superficial

6a The ribs are deep to the navel.

7a The intestines are inferior to the lungs.

inferior

7a The heart is inferior to the clavicle.

8 The wrist is in midline

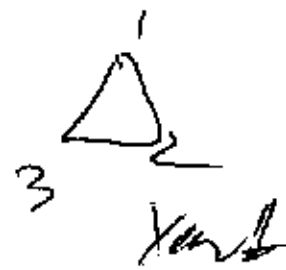
1st The plane.

9 The Rt lungs are

2nd

10 The Lt

3rd



10 What Plane - Rt - Left

18-4-2014

1050
Seneca 4

Name ABDUL-BASIM FATALLY

Describe the body region each of these terms refer to:

1. Abdominal	abdomen which is inferior to the shoulders
2. Acromial	refers to the part of the scapula attached to clavicle
3. Antebrachial	refers to the antebrachium between brachium & A
4. Brachial	refers to the arm
5. Buccal	refers to the mouth which is anterior to the spine.
6. Carpal	refers to the joints of the fingers distal to the wrist - coronoid
7. Celiac	refers to the celiac artery, part of the aorta.
8. Cephalic	refers to the head
9. Cervical	refers to the neck as in the cervical vertebrae.
10. Costal	refers to the ribs
11. Coxal	refers to the coxix
12. Digital	refers to the fingers
13. Dorsal	is used with ventral to describe using coronal plane
14. Femoral	refers to the bone femur in the thigh.
15. Frontal	refers to the head as opposed to occipital
16. Genital	refers to the scrotum, the v
17. Gluteal	refers to the gluteus maximus, minimus muscle.
18. Inguinal	refers to the part between the femur & pubic bones
19. Lumbar	refers to the vertebrae superior to the coccyx
20. Mammary	refers to the glands on the chest inferior to the upper quadrant
21. Nasal	refers to the nose, midline on the face.
22. Occipital	refers to the back of the skull posteriorly.
23. Oral	refers to the mouth which is inferior to the nose
24. Orbital	refers to the orbits of the skull lateral to the nose
25. Otic	refers to the ears
26. Palmar	refers to the palm of the hand.
27. Pectoral	refers to the chest, anteriorly
28. Pedal	refers to the feet which is distal to the knee cap
29. Pelvic	refers to the pelvis, bones that support the abdomen
30. Sacral	refers to the sacrum
31. Sternal	refers to the sternum on the midline
32. Umbilical	refers to the umbilicus
33. Vertebral	refers to the vertebrae

The brachium is between the upper segment of the arm from the shoulder to the elbow.

NURS1002

2404

2014

0810

208

ABNS 1405011

INTRODUCTION

To

ANATOMY & PHYSIOLOGY

Intro duct to-day at-

Cells to-morrow -

Sagittal plane - 1/2 of body - mid sagittal

Frontal plane - anterior

Axial - top and down

Systems: Skeletal ①

Digestive ②

Nervous ③ Endocrine

Muscular ④

Respiratory ⑤

⑥

ML

medial lateral
proximal
distal

BRXA

Science

ATP Na⁺

K⁺

Ions

Directional
Terminology

IS
ML

PD

AP

axis

Geometry

Proteobacteria

① Positive Feedback loop mechanisms # 1: delivery

2: lactation

3: clotting factors 12 at

② Negative Feedback loop mechanisms # eating, flight.

Breathing - running

adrenaline -

Insulin -

IT

Homeostasis - positive goes beyond limit

negative do not occur -!

0840

Semester 1

YEAR 1

NOTES/002

ABNS 1405D11
Anatomy & Physiology

BRVA

2404

2014

Q13

appendix is part of lymphatics

abdominal organs - from small to large intestine

16th 2010 - 20

11 weeks surgery

Pancreas - liver -
kidneys
pancreas
adrenal glands
liver,
arteries - pancreas.

RT - U Q

Stomach, spleen - lymphatic

to
major part of
pancreas
adrenal
kidneys -
let pancreas
descent
colon
N
phrenic
here -
phrenic

Lt up Q

Substernal pain

Sigmoid

Semester 1

YEAR 1

NWRS 1002

ABNS 1403011

BRNA.

amr Per
Leal

Shohu

44.

Name
Clockwise.
==

2404

2014

0153

hinder
Legion.

Flial bone.

Semester 1

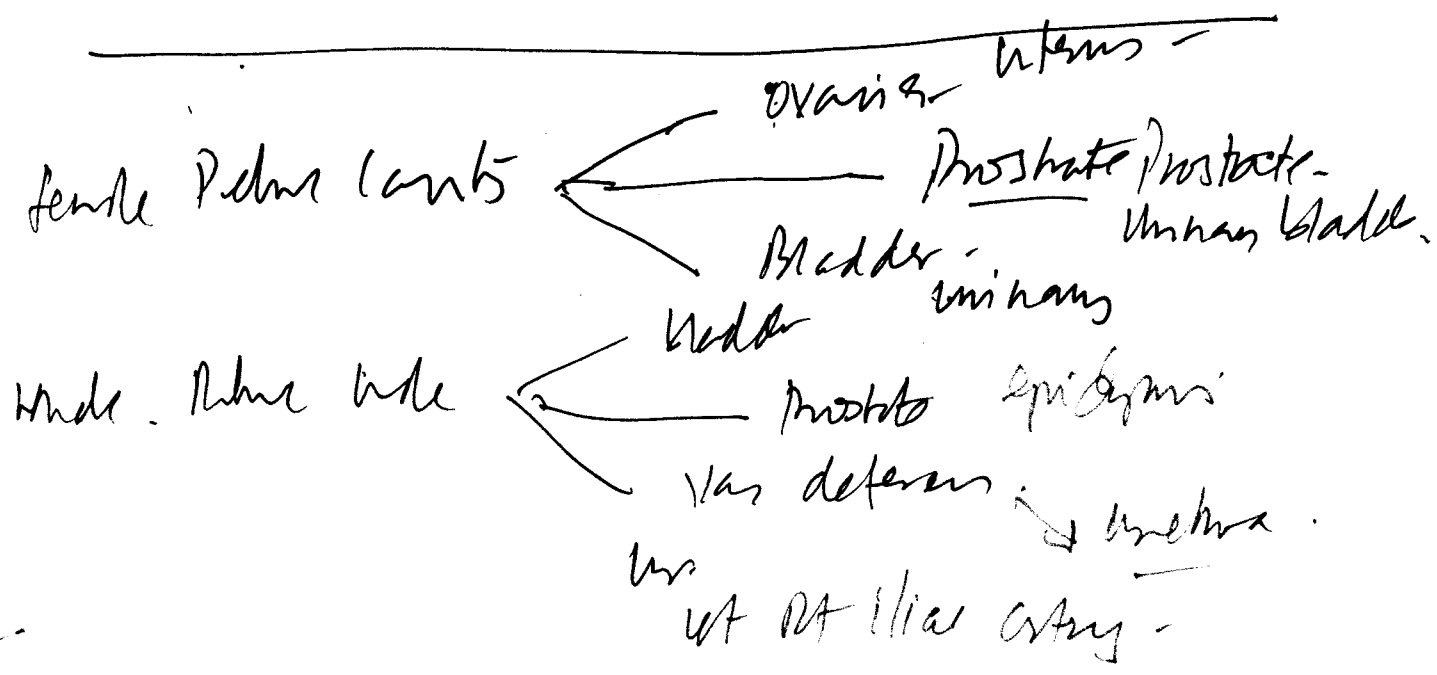
Year 1

2404
2014

What makes up a cavity?

- Anterior
- 2 1 VENTRAL Cavities.
- a Thoracic cavity
 - b abdominal cavity.
 - c pelvic cavity

- Posterior
- 2 Dorsal Cavities.
- 1 Cranial -
- mediastinum
H, esoph - Bronchus



1015

2404
2014

Serous membranes -

- > line the trunk cavities and
- cover the trunk cavities
- > fluids -

hydrothorax

Visceral → Deep

Parietal → upper

- Peritoneum - pleura - fluid -

> Serous membranes secrete

fluids that fill the space between the

parietal and visceral membranes.

Visceral

fluid

parietal

Suction

negative
pressure
maintain

1027

2 layers -

Parietal
Visceral

negative pressure -

Suction

Size

Pericarditis -

Gallbladder

in peritoneal

cavity

Pleural tapping

1034

Semester 1

Leave spaces in puncture wound =

YEAR 1

Learn
he knows
lung
collapse

NURS1002.

ABNS 1405011

BAYA.

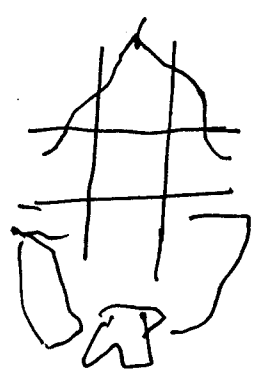
2404

2014

(Ana-landian (PR.) AHCat anasth
CHeckz mammal (CPA)

12 par, 2 floats, 2 - not attached -
8 fine wls - 4 take - 2 flow - 214

Rt upper



RT Hypochondr PMA	Epigastric	Perium it Hypo gastric	Lt Rt upper.
Lumbar	umbil ilic	Lumbar	
Rt ilic	Hypo gastric	Lt ilic	Anasth Lt

Rt lower.
indig.
Rt upper
Quadrant
Rt lower
Quadrant
falling
abdominal region
1. 4 quadrants

Stomach -
Lt upper
Q
LUO
Lt lower
Lower
Quadrant
9 regions.

4
9

Semester 1

XXXX 1

NURS1002

ABNS 1405011

Rep

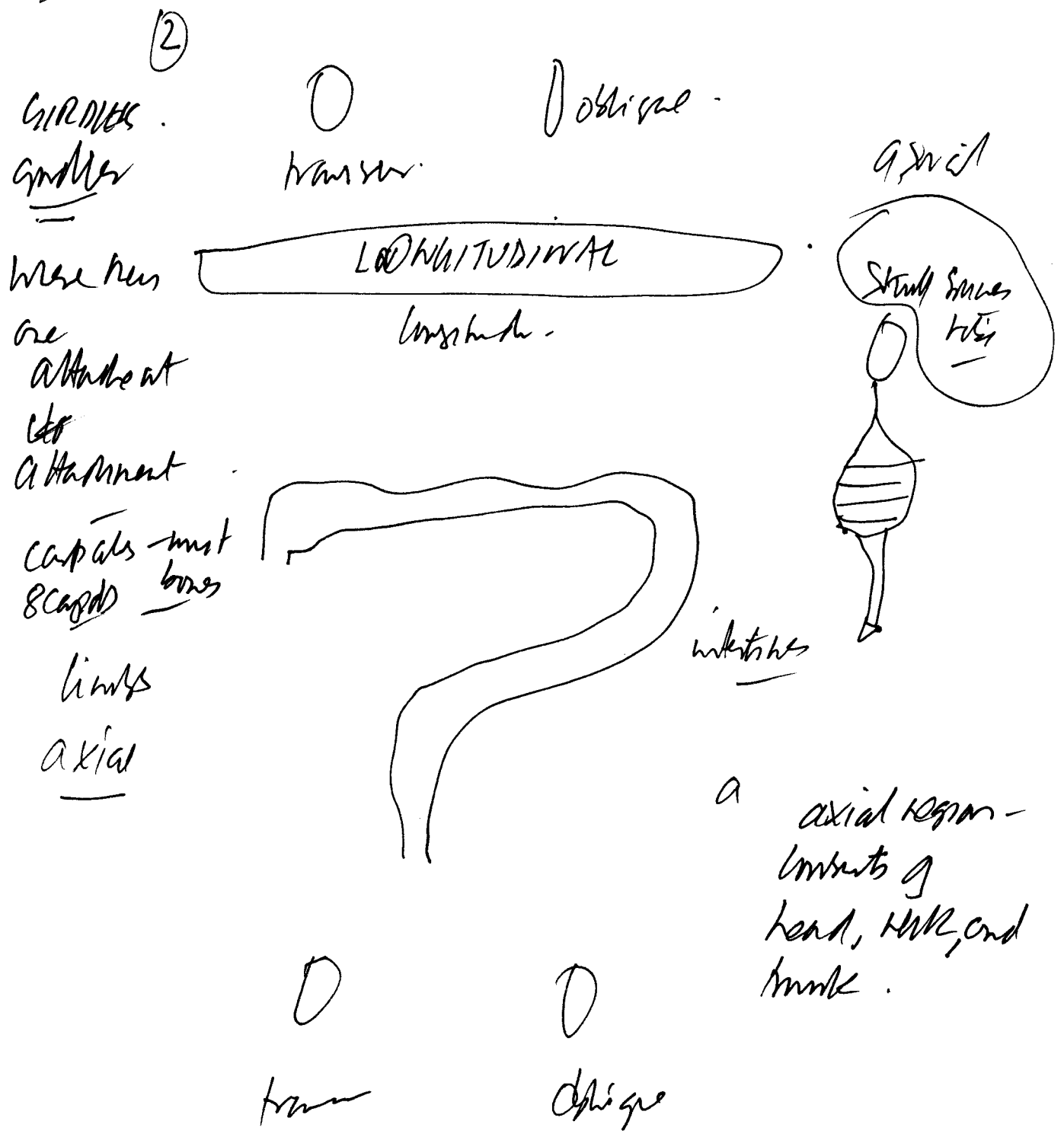
BRYA

2404
2014

- INTRODUCTION Anatomy in 18th
- 1. Debridement - mechanical scalpel.
 - chemical -
 - antibiotic dressings.

18 hrs

repeats 1. longitudinal based on longest axis



Semester 1

YEAR 1.

NUR 9/10/2

ABN 5/1405011

BORNT.

2404
2014

Tibia	Calcaneum
Femur -	18 Capital
Patella -	8
Pelvic Bone	Tarsal 8 bones.
Femur -	Metatarsals -
Pelvic Bone	=
Axial bones -	appendiculars -

Girdles are attachment points

AXIAL BONES

Cranial, Vertebrae, Cervical, Sacral, Sternum,
occipital - frontal, parietal, temporal, occipital,
Sphenoid, sphenoid, temporal - occipital -
temporal, temporal, axis, atlas - 11 =
frontal - occipital - temporal - parietal - temporal.
frontal, mastoid - Vertebrae, 1. ~~temporal~~ atlas,

7.	Cervical	hairs =	12
			2 Pouches
12	Dorsal	hairs -	7 attached to Sternum.
6	Lumbar	hairs =	
			CPR -
1	Sacral	hairs -	Landmark of
			Anatomical Landmark for CPR.
			LANDMARK.

Schaefer 2

YEAR 7

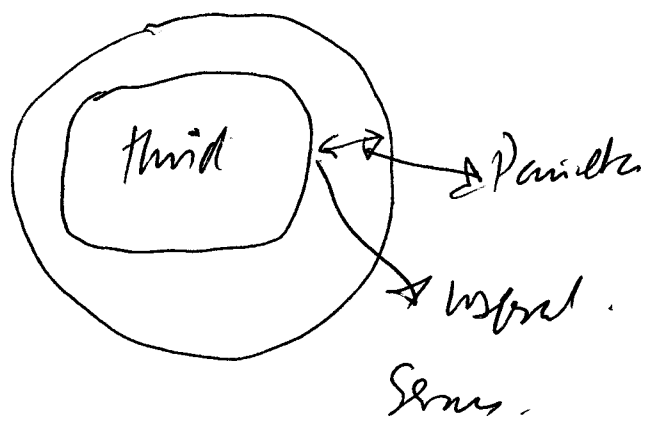
NVTS1002

ABAS 1465014

B124A.

2014
2404.

Heart Pericardium $\left\{ \begin{array}{l} \text{Visceral} \\ \text{Pericardial space} - \text{Pericardium} \end{array} \right.$
Cavities $\left\{ \begin{array}{l} \text{Visceral} \\ \text{Pericardial area} \end{array} \right.$



Phagocytosis

Cells
organelles
cellular
membrane

Cellular

Division

mitochondria

ribosomes

transport

proteins

carbohydrates

lipids

chromosomes

Disorders

TERMINOLOGY AND BODY ORGANIZATION

The body has a ventral cavity, consisting of several subdivisions and containing the internal organs collectively referred to as the VISCERA. Other minor cavities include nasal, oral (buccal) orbital, middle ear, synovial). Older texts may discuss a dorsal body cavity consisting of cranial and spinal cavities.

Using your text as a reference, name the subdivisions of the ventral cavity that the following organs are located in:

Stomach: The Abdominal cavity

Liver: The Abdominal cavity

Lungs: The Thoracic cavity

Urinary bladder: The Pelvic cavity

Pancreas: The abdominal cavity.

Spleen: The abdominal cavity.

Esophagus: The Thoracic cavity

The lungs: The Thoracic cavity

Adrenal glands: The Abdominal cavity

20/04

2404 Systems: List a function of each system below and examples of organs or structures in each.

- 1: Circulatory: transports nutrients to cells
- 2: digestive: breaks down food into peptide, polypeptide, amino acids, sugars.
- 3: endocrine: releases proteins, fluids that target organs such as hormones
- 4: Skeletal: manufactures erythrocytes
- 5: muscular: moves bones
- 6: reproductive: replicate the species.
- 7: Integumentary: protect the other systems.
- 8: nervous system: handles coordination, orientation in space, and time.
- 9: Respiratory system: supplies the cells with oxygen and removes carbon dioxide.
- 10: Urinary system: removes excess fluids, and salts.
- 11: lymphatic: protects the organs from invading pathogens.

Levels of Organization:

A portion of the level of organization of the body, as presented in the text consists of the cell, tissue, and organ levels. Given the following, classify each into the correct level.

Stomach is an organ.

Muscle is a tissue.

Brain is an organ.

Skin is an organ.

Cartilage is a tissue.

Pancreas is an organ.

Neuron is a cell.

Epithelium is a tissue.

Thyroid gland is an organ.

Bone is a tissue.

Blood is a tissue.

Leukocyte is a cell.

Nurs1002

Exercise 2. Name a plane of reference that would pass through both structures (more than one answer may be possible for some of them).

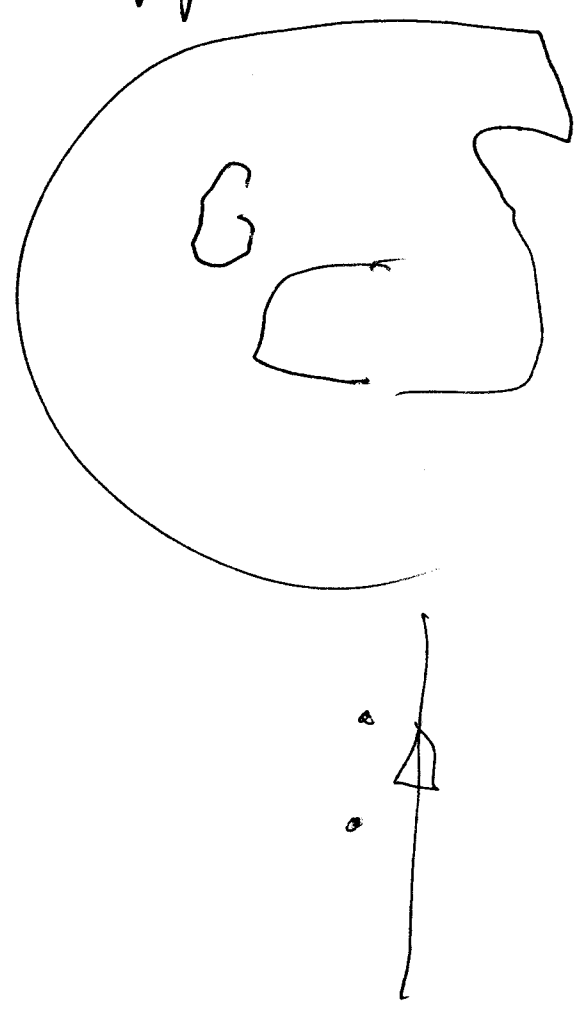
BREAST

Planes of Reference ~~that would~~: [Median (midSagittal), Sagittal, parasagittal, frontal (Coronal), transverse (cross section)]

A: patella is parasagittal to the sternum.

B: Acetabulum is sagittal to the ispubis symphysis.

C: Cheek



ABDOMINAL PELVIC REGION & Duct

Kidney

Kidney.

Bladder.

Anatomical Directional Terminology ::

For each of the following relationship (A-H), perform exercises 1 and 2.

Exercise 1: Use the directional term to describe the relationship of the structures as listed.

Directional terms: Superior, inferior, dorsal, ventral,

proximal, distal; medial, lateral.

A: patella (kneecap) is inferior to the sternum.

B: acetabulum (hip socket) is lateral to the pubic symphysis.

C: Cheek is ^{dorsal} inferior to the ear.

D: ankle is distal to the shin.

E: Elbow is proximal to the wrist.

F: vertebral column is dorsal to the umbilicus.

G: chin (mental region) is inferior to the forehead.
Mental region

H: hipbone is medial to the scapula.

Nurs 1000

hw 3/24

02-05

hw 3/24

1. Inflammation

2.

Tissues H

A: fungus 5

R: bacteria 5

C: virus 5

D: parasite 5

Theodan - Uniform Rescues -

0842

FREUDIAN Psychology -

2204

The last task of a toddler from birth - Psychology

then anal - Potty training -

Contemporary psychology obsessive-compulsive -

Sue - Hands wash 10 times - OCD -

? During potty training - parents were too

strict - Freudian Stages of task satisfaction

0846

NEW Practices discipline & Clinical judgement -

1: Hyperinflation ^{lungs} before birth -

2: hand getting in the way - lean forward -

3: Why do, this, ?

Why
Rational
nature
Science

0850

□ Theory defines what nursing is, what it does, and the goals or outcomes of nursing care.

method
APIE

Assessment

□ Nursing is the synthesizing many theories.

□ Nursing theory provides the theoretical foundation.

of the profession.

Concepts - theory - predicts - phenomenon.

Predictive
Theories

A theory is a set of concepts and propositions that provides an orderly way to know phenomenon.

0904

2204

2014

- always take Thermis
1. People need oxygen to breathe =
 2. When there is no oxygen to breathe
 3. People suffer from hypoxia - sleep -

1. People move faster when they are hot.
2. A person puts on weight drive
3. People move less faster -

1 Phenomenon = O_2 .

Concepts → lungs, tubes, in
Pneumothorax

assumption -

Organized System of Ideas:

Concepts
Propositions > Theory > describes > PHENOMENON
Assumption
Predicts
Relationships

0922 -

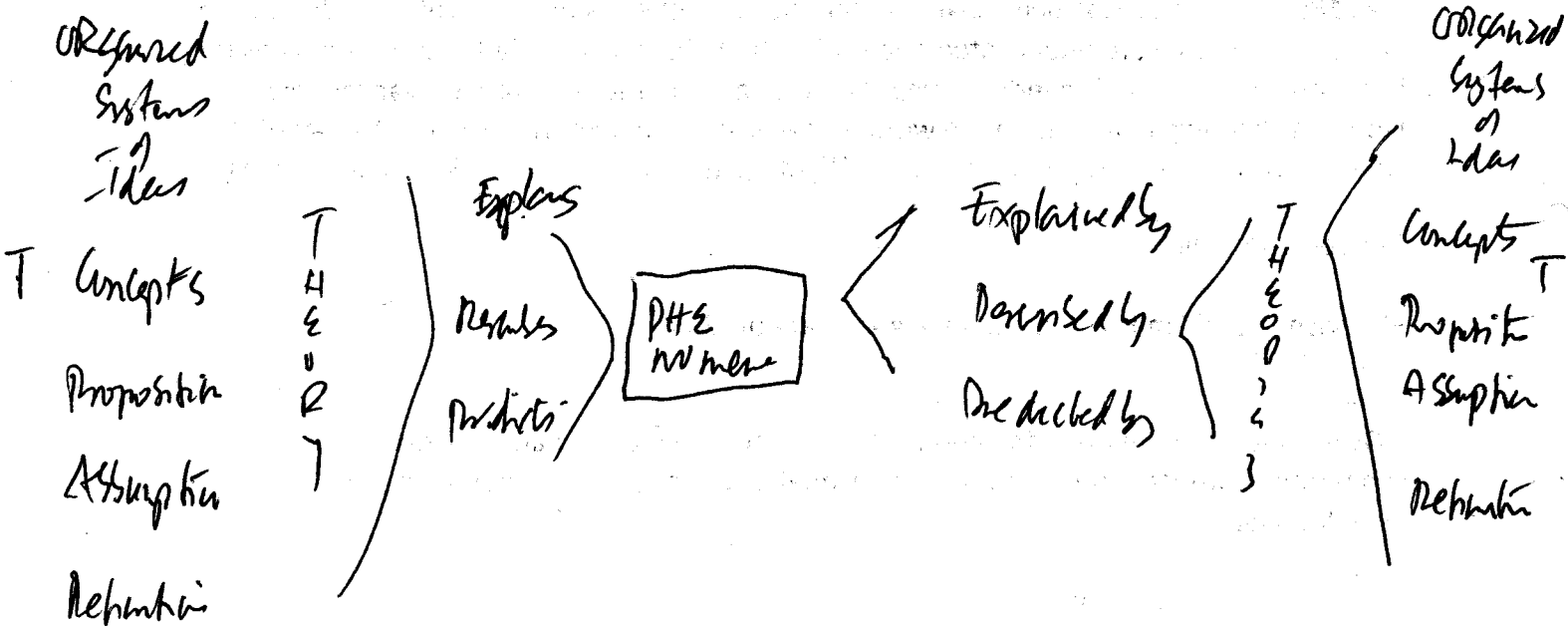
Concepts and propositions

2204

are the elements of a theoretical foundation

2014

A **Theory** is a set of concepts and propositions that provides an orderly way to view phenomena



Concepts

- Building blocks of a theory
- Labels or names for phenomena / observable facts
- Assist us in formulating a mental image about an object or situation.

Conceptual frame

2204
2014

Conceptual framework

A graphical representation

abstraction

1: context can be empirical abstract or empirical.

2: ~~metaparadigm~~ - shared realities - parts that we take for granted

3: In Nursing - Paradigm. Person, Nurse.

① Person

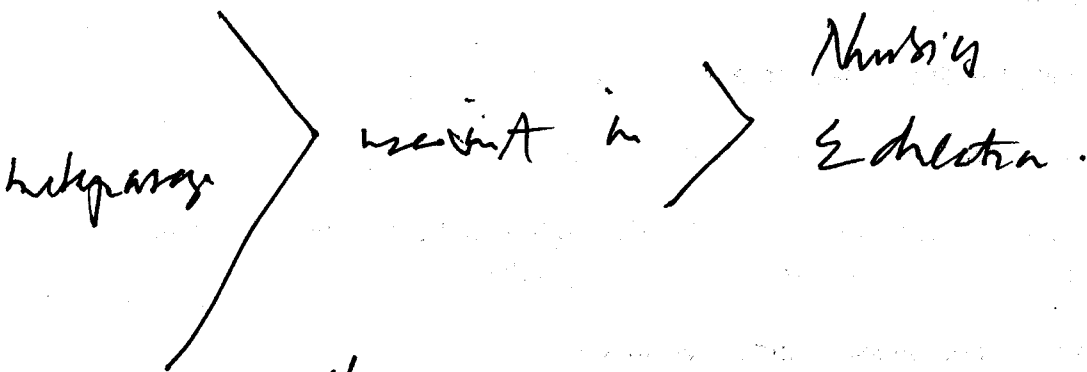
② nurse

③ Health

④ environment.

Paradigm. A

4:

Almost ^{all} nursing theory try to explain the

④ paradigm

0944

Contemporary
Levinson - Transcultural

Nursing

1: PERSON

55 slides — in the Esplanade

for

Assumptions

Human

L-P

#B * Human core is universal and, that
is seen in all cultures. All human beings are believed
to be coming —

Health

H * It is presumed that health is
viewed as 'being universal across
cultures but defined within each culture
in a manner that reflects the beliefs, values,
practices of the particular culture.

* Environment

Levinson speaks world view, social
Structure and environmental context

* Nursing

She defines nursing as a learned human
HC. Art and science that focuses upon personal
Care.

0830 Tomorrow - 1-2-3-4-5 20 mins - ^{discussion} Open - Q&A.
15- 5 Q&A

By Friday - Report by body on [4 meta - description cont.
Intro - Summary }

1. Description =

2. 4 meta =

3. Intro =

4. Summary =

5. Research / application. A then a critical practice.

tot claim: the whole group a

Session 1 Group 1-5 should have

Year 2

1: Leininger Leininger's Transcultural Nursing.

2: Orem

2

3: Popper Logan

4

4: Poplan

3

1-5: Nightingale

1

Summary

assumption

intake

Research

assumption, paradigm - explain & relate - abstract

Person, environment - health - nurse.

used in actual clinical practice.

application to

clinical

practice

made a L assumption that the care of a person should be aimed to the person's values, beliefs and.

Sum are model - concept

Intake - Research



Group Presentation Rubric

Module: _____

Topic: _____

Date: _____

Parameters	Criteria				Total	Remarks
	16-20	11-15	6-10	1-5		
Content/Knowledge - refers to the relevance of the information presented and the mastery of the topic	The data presented were of great relevance to the topic assigned and were enough to meet the objectives. Showed excellent mastery of the topic with enough examples, applications and implications.	Great deals of informations were presented but not enough to meet the objectives. Showed minimal mastery of the data with less examples, applications and implications.	The data showed minimal relevance to the topic assigned with less attainment of the objectives. No mastery of the topic with superficial applications and implications.	No relevance to the topic assigned. Poor knowledge of the topic with no examples, applications and implications.	_____/20 X 100 = ____ X 50%	
Organization - refers to how the members organized the presentation for the audience to follow	The informations were presented logically with clear transition from one concept to another. No interruptions during the presentation.	The topics were presented logically with clear transition from one concept to another. However, minimal interruptions were noted during the presentation.	The topics were presented with less organization and notable difficulty in moving from one to concept to another. There were several interruptions during the presentation.	No organization was noted throughout the presentation. Informations were scattered from one concept to another.	_____/20 X 100 = ____ X 30%	
Presentation - refers to the creativity, resourcefulness and time management.	Utilized appropriate visual materials showing creativity and involved the audience during the presentation.	Utilized appropriate visual aids with less creativity and minimal participation from the audience. Finished the presentation.	Utilized a simple routine visual aids showing lack of creativity with minimal to almost no audience	No creativity during the presentation. No audience participation. Failed to finished the presentation on time.	_____/20 X 100 = ____ X 20%	

[illegible]

bmd'12

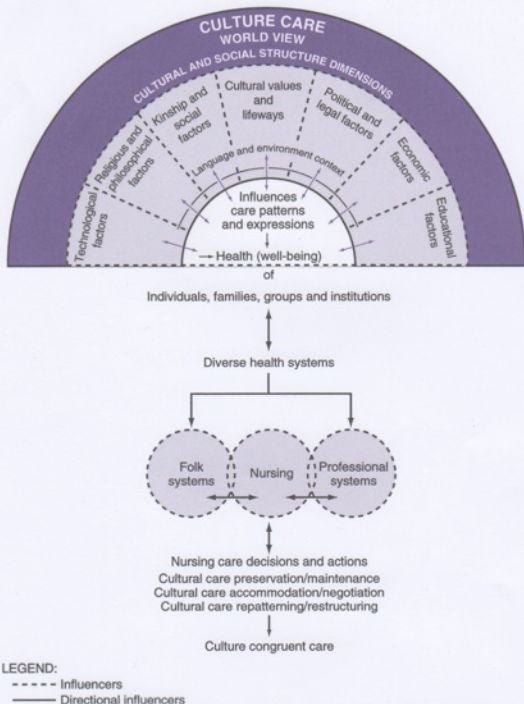


Figure 7.4 Leininger's sunrise model depicts dimensions of culture care diversity and universality. (From Leininger, M. M. [Ed.]. [1991]. *Culture care diversity and universality: A theory of nursing* [p. 43]. New York: National League for Nursing Press. Used with permission.)

Page 1 -
BRUA.

Nurs 1001

The Theory of Hildegard Peplau -

1033

Ann -

15 Sep 1909

1947

1953

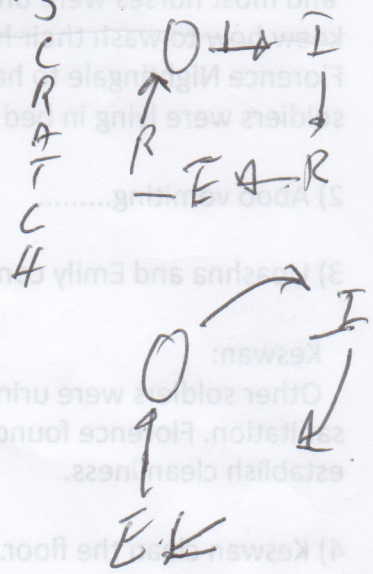
Nurse-client relationship
the foundation of nursing
interpersonal relationship.
Seven nursing role.

Ed

7

- Stranger Role: →
- Resource role: →
- Unlabeled role: -
- Supportive role: -
- Active leader role.
- Technical expert role:

SRISA T. sketches



The interpersonal relationship theory - major

That approach
Object - identification
Explanation - Resolution - Termination

Semester 1

Year 1

2304

2014

FDI
Investing in local businesses by foreign citizens often involves stock ownership of the business.

PRESENTATION
Theorizing

Nightingale :-
metaparadigm

chart -

Nursing

1st Patient s: holistic approach.

chart

NURSE - Nurse code.

heal
achieve met
gather

0852

Wash hand - vijay kumar
clean.

2nd

3rd

Health :- Diet - Nutrition Education

Proper selection of food and understanding diet -

Noise - Ventilation & warming - light.

4th

Environment ab. Environment -

Noise, light, ventilation, weather - health

0900 Patient drainage.

Ordy -

Antis - ozone layer - protection -
Direct sunlight

Can drink -

0912

Interpersonal means Holdegard explain.

The Environmental theory of Florence Nightingale.

Conceptual metaparadigm - Care - person
- Health - environment.
- Health -
- Environment -

0914

Semester 1

①

Year 1

NURS1001

2304

2014

0920

Presentation 4 metaparadigm

BRVA

Comment: - Believe that pt can repair
themselves - put that person out that
future will restore health &
Assumptions of

PRESENTATION 2
Team: 6 - 5 F/1m

0924
+

DOROTHY OREM THEORY

Baltimore, Maryland -

10/4

10/30

5A

Parts A: Self care

B: Self care deficits agents

C: Nursing system

D: Therapeutic Self care

E: Self care requisite

Social, emotional, leading

Self care agent is the human ability to manage

Self care

Therapeutic self care - is the total self care action -

Semester 1

(A)

10/21

NURS1001

Roper, Logan & Tierney

BR4A

Theory

Activities of Daily Living

1115
2304
2014.

✓

1121

12

Activities of daily living.

Assessment tool - Checklist

1139

- Life span continuum -

Birth -

- -

Death

5 Assumption

1: Client's being is generally human & L.

Phenomena & behaviors with being.

Physiological & sociological ~~with~~ well-being

Rebut Selfcare deficits =

metaparadigm. # Person: dependent.

Environment -

Nurse

N
E
P
H

P
H
E
N

Met-Paradigm - PHEN

The theory of Nurs system - humanistic.

Patient & nurse action

3 1: health

2:

4:

1. A Organ thevedman. with physical ad environment.
Learner for developing of self & maintaining her
well-being basis

charts 2

3

Year 1.

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Orem's Self Care Model.

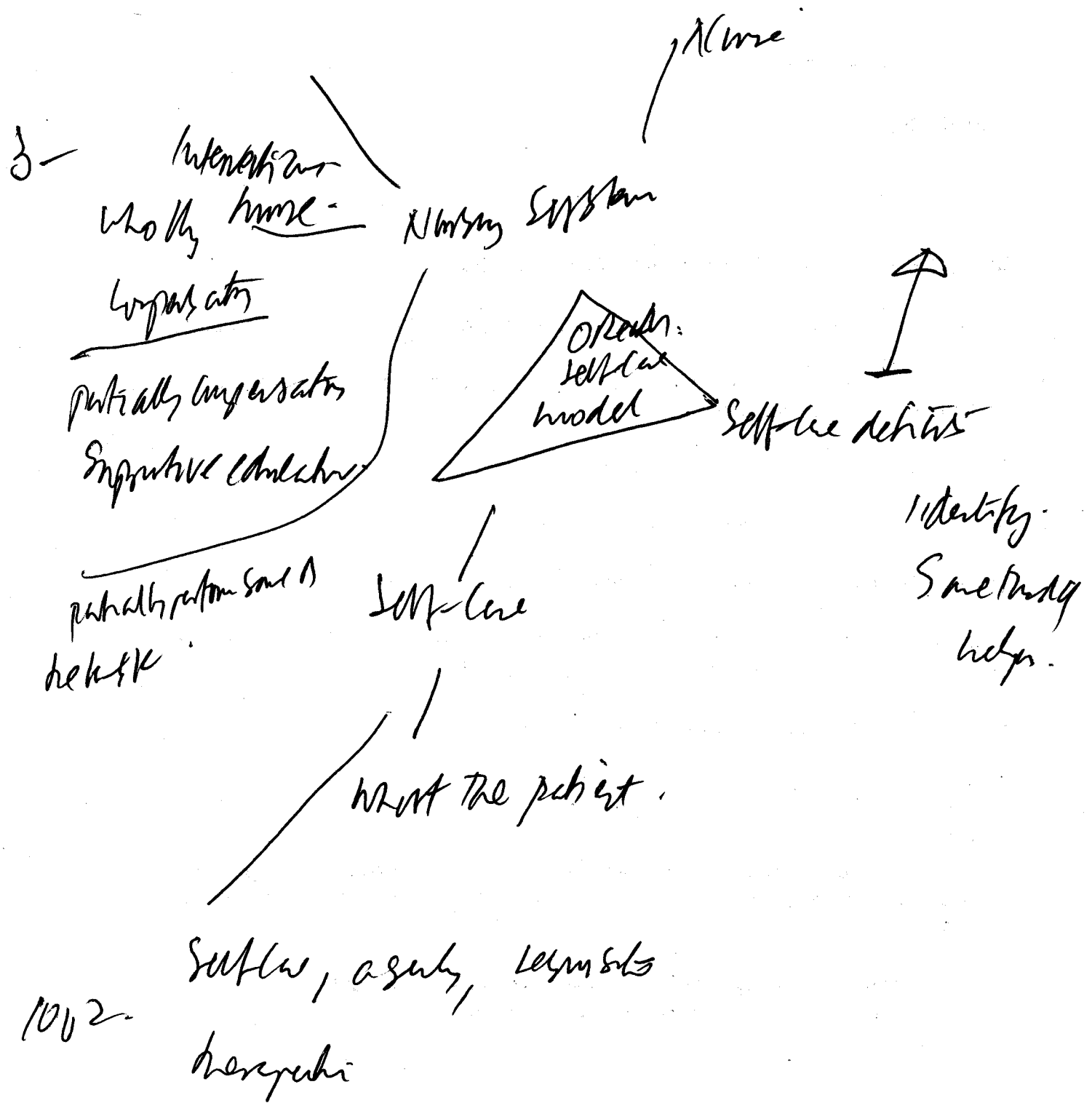
BRAMA

I show confidence in what you

are doing

Self Care - nursing system - replace self.

II Scenario

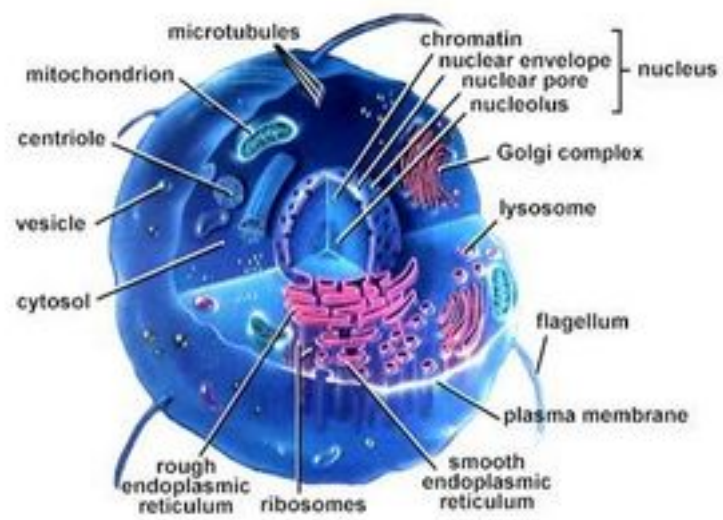


Semester 2

④

Year 1

Homeostasis: The Subject of Physiology 4 Origin of Our Milieu Interieur 4 Living Things Are Open Systems 4 Body Fluid Compartments and Their Contacts with Total Body Water 8 Interstitial and Intracellular Fluid Compartments 8 Alterations in Body Fluid Compartments Dehydration 8 Infusion of 2 L of Isotonic Saline (150 mmol/L NaCl) 9 Infusion of Isotonic Urea (300 mmol/L) 9 Rapid Infusion of Pure Water 9 Ingestion of 100 g of NaCl Tablets 9 Infusion of Isosmotic Saline (NaCl) Solution Containing 20Infusion of Isosmotic (58 9 the Outside World 4 Ionic Composition of the Major Fluid Compartments 5 Body Fluid Osmolarity and pH Measuring the Sizes of the Body 6 Fluid Compartments 6 Plasma Volume 6 Extracellular Fluid Volume 8 CHAPTER ?1 The Internal Environment STANLEY G. SCHULTZ



Psychology



The biopsychosocial model of disease

My long-term health conditions are biological in origin, but the impact has been felt physically, psychologically and socially. My long-term health condition can't be treated just through the biological medical model alone. . . .



pathology
disease
symptoms
science
doctors
tests
treatments



depression
guilt
stress
anxiety
identity
tears



hobbies
isolation
family
money
career
friends
burden

“The medical support keeps me alive, but it is the psychological and social support that enables me to live.”

Module 3.

PSYCHOSOCIAL CONTEXT OF HEALTH AND ILLNESS.

(75 hours/5 Credits)

AIMS.

- ❖ For the students to understand how the psychosocial factors have an impact on our health/ health of the nation.
- ❖ For the students to have an understanding of their own psychosocial profiles, help them to understand other people's behaviour and relate acquired knowledge to the nursing profession.

LEARNING OUTCOMES/ OBJECTIVES.

- Apply the psychosocial principles while performing nursing duties. Understand the psychodynamics of human behaviour.
- Differentiate how sociological and psychological processes contribute towards well being and illness.

- Understand the psychodynamics of human behaviour.
- Describe the main institutions of the society, their structure and functions.
- Identify the psychological and sociological needs of the clients to help in planning their nursing care.

- Understand the communication process and develop the necessary skills to communicate effectively.
- Develop positive attitudes towards individual, family and the community.

UNIT ONE

Introduction to Psychology

A large, stylized black outline of a human brain is positioned on the right side of the slide, partially overlapping the text. The brain is shown from a top-down perspective, with the two hemispheres clearly defined by a central vertical line. The gyri and sulci are represented by simple, rounded shapes. Below the main title, there is a solid orange horizontal bar.

The word psychology is derived from the Greek word psyche, meaning 'soul' or 'mind'.

Psychology evolved out of both philosophy and biology - Greek thinkers , Aristotle and Socrates.

Throughout psychology's history, a number of different schools of thought have formed to explain human thought/perspectives and behaviour.

Psychology

‘Psychology is the scientific study of behaviour and mental processes. Behaviour includes all of our outward or overt actions and reactions, such as talking, facial expressions and movements. Mental processes refer to all internal, covert activity of our minds, such as thinking, feeling and remembering.’ (Ciccarelli & Meyer 2006).

Psychology is an applied discipline involving the scientific study of human behaviour and attitudes based on the surroundings and environments in which we live. Its objective is to understand individuals by establishing certain principles and research methods specifically intended for analyzing the behavioural patterns of the subject. For this purpose, it analyzes the reaction of many organs and senses in the human body to verify its influence in terms of preference and attitude.

Psychological factors include such variables as lifestyle (e.g. smoking, drinking) and personality. It also includes such variables as cognition, thinking and interpreting – and beliefs.

Social factors are both broad and deep. We all have relationships with others, whether these be our family, our friends or our work colleagues.

Definition

In 1966 Virginia Henderson cited Siviter (2004) stated: ‘ Nursing is primarily assisting the individual in their performance of those activities contributing to health, or its recovery that they would perform unaided if they had the necessary strength , will or knowledge.’

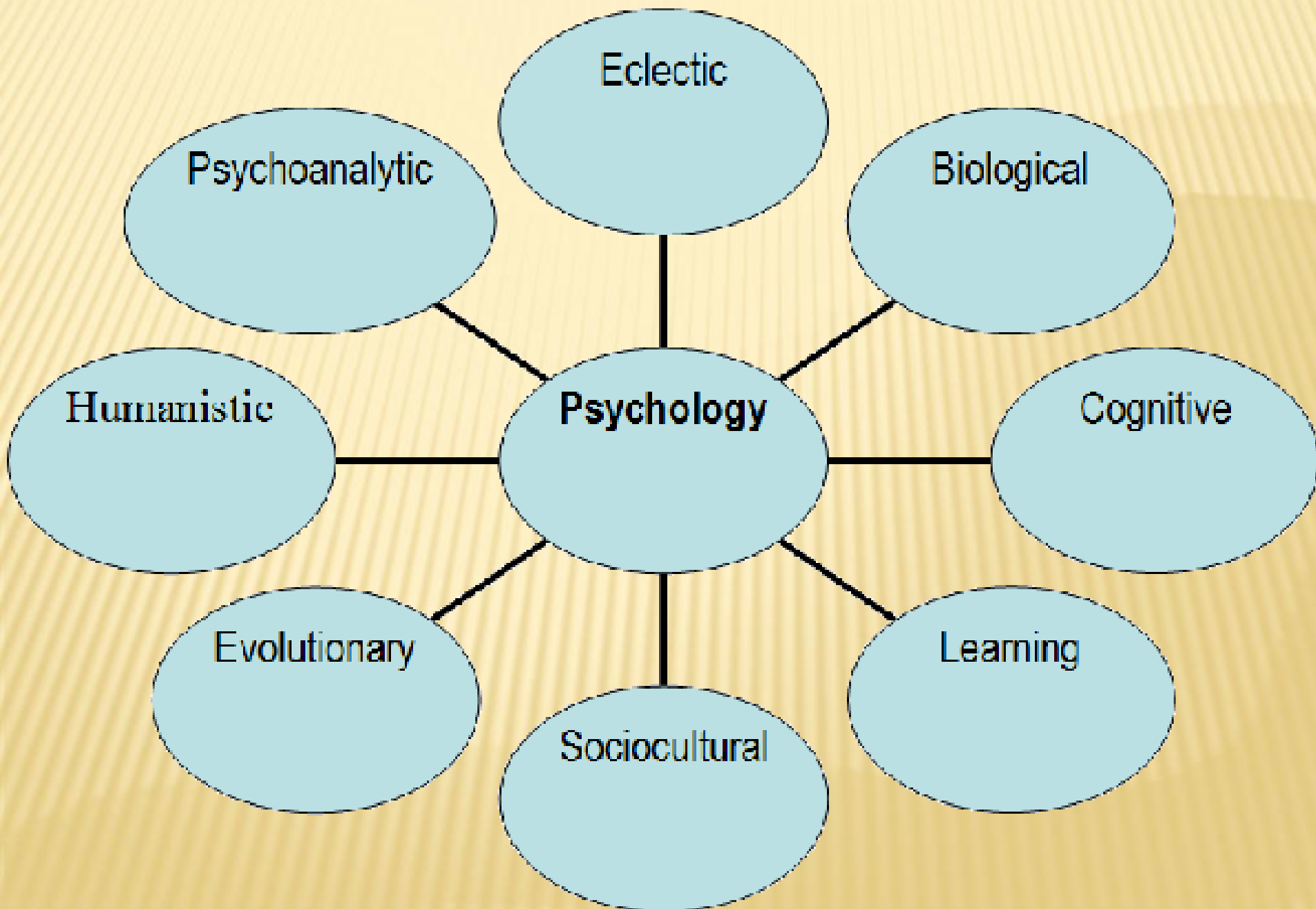
The Royal College of Nursing (2003, cited Siviter 2004) defined nursing as : ‘ the use of clinical judgment in the provision of care to enable people to improve , maintain, or recover health, to cope with health problems and to achieve the best possible quality of life whatever their disease or disability until death.’



Cognition
Memory
Learning
Personality
Development
Perception
Physiology
Society
Home
Language

Psychology

Perspectives in Psychology



Definition

Health is derived from whole, hale and healing, signaling that health concerns the whole person and his/her integrity, soundness, or well-being.

‘Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity,’ (World Health Organization, 1946 cited in Wills p.4).

Health promotion was defined in the Ottawa Charter (WHO 1986) as being centrally concerned with empowering people to take greater control over their health and thus includes a range of strategies to strengthen communities, develop supportive environments and inform and educate about health issues, (cited in Naidoo and Wills p.4).

The goals of health promotion are to help modify their lifestyles and make choices to improve their health and quality of life.

Health education is very important in helping enrollees/patients to accomplish this goal.

What is Sociology?

Sociology is the ‘ the study of human society’. The main theoretical perspectives are Functionalism, Maxism, Feminism and the New right.

What makes psychology a science is not that facts have been firmly established, but that the scientific method is applied to the subject matter to be studied.

Psychologists are also concerned with animal behaviour and with the neurophysiologic processes which accompany or give rise to behaviour. They study not only human behaviour, but also human experiences, language and other forms of communication.

They are interested in individual differences, be they genetically determined or occurring as a result of learning; they study how individuals and society interact, and how they behave as members of small and large groups. **Psychology is of interest to nurses because its subject matter is that of human behaviour. Nurses meet people every moment of their working day.**

The relationship with others into which nurses enter in the course of their work, make the job interesting and rewarding. Some of the people the nurse meets may behave in a manner which is difficult to understand. The nurse in turn needs to understand her own behaviour and how it might affect relationships with patients.

Mental disorders are brain disorders that variably affect aspects of cognition, emotion, and behaviour. Mental disorders are a result of the interaction between genes and environment.

Psychosocial rehabilitation is the development of skills and supports necessary for successful living, learning, and working in the community.

Psychosocial health is basically how we see life and our experience and is fundamental in a person's general well-being, encompassing mental, emotional, social, sexual and spiritual aspects of health.

The roots of the term psychosocial health lie in the World Health Organization's (1948) **definition of health** which states that health is a 'a state of complete physical, mental and social well-being and merely the absence of disease and infirmity'.

Psychosocial health is affected by a number of factors, some internal and others external. External influences are those parts of our life experiences that we have little or no control over, for instance our family and where we grow up.



Psychology

Internal factors associated with psychosocial health are equally as important as the external factors; however they are harder to see as they are inside the person. Internal factors such as self-concept, hereditary traits, physical health status, physical fitness level, hormonal functioning, and mental, social, sexual, spiritual and emotional health all have an impact on the individual's psychosocial health.

ACTIVITY 1.

Spend a few minutes writing a list of things that you believe a nurse does and then spend a few minutes writing down what you believe psychology is.

Psychology seeks to understand why people behave ,think and feel the way they do, individually and in groups, in all areas of life including health.

Psychologists not only seek to predict behaviour but also to change behaviours to enhance well-being and quality of life.

Why study Psychology ?



Transferable skills



Develop oral, visual and written communication, problem solving, numeracy and statistical skills, critical and creative thinking, decision making, organizational skills, team working , and IT skills.



**Spiritual
Wellness**



**Physical
Wellness**



**Mental
Wellness**



**Emotional
Wellness**

Self



**Environmental
Wellness**



**Social
Wellness**

HEALTH, WELLNESS AND ILLNESS





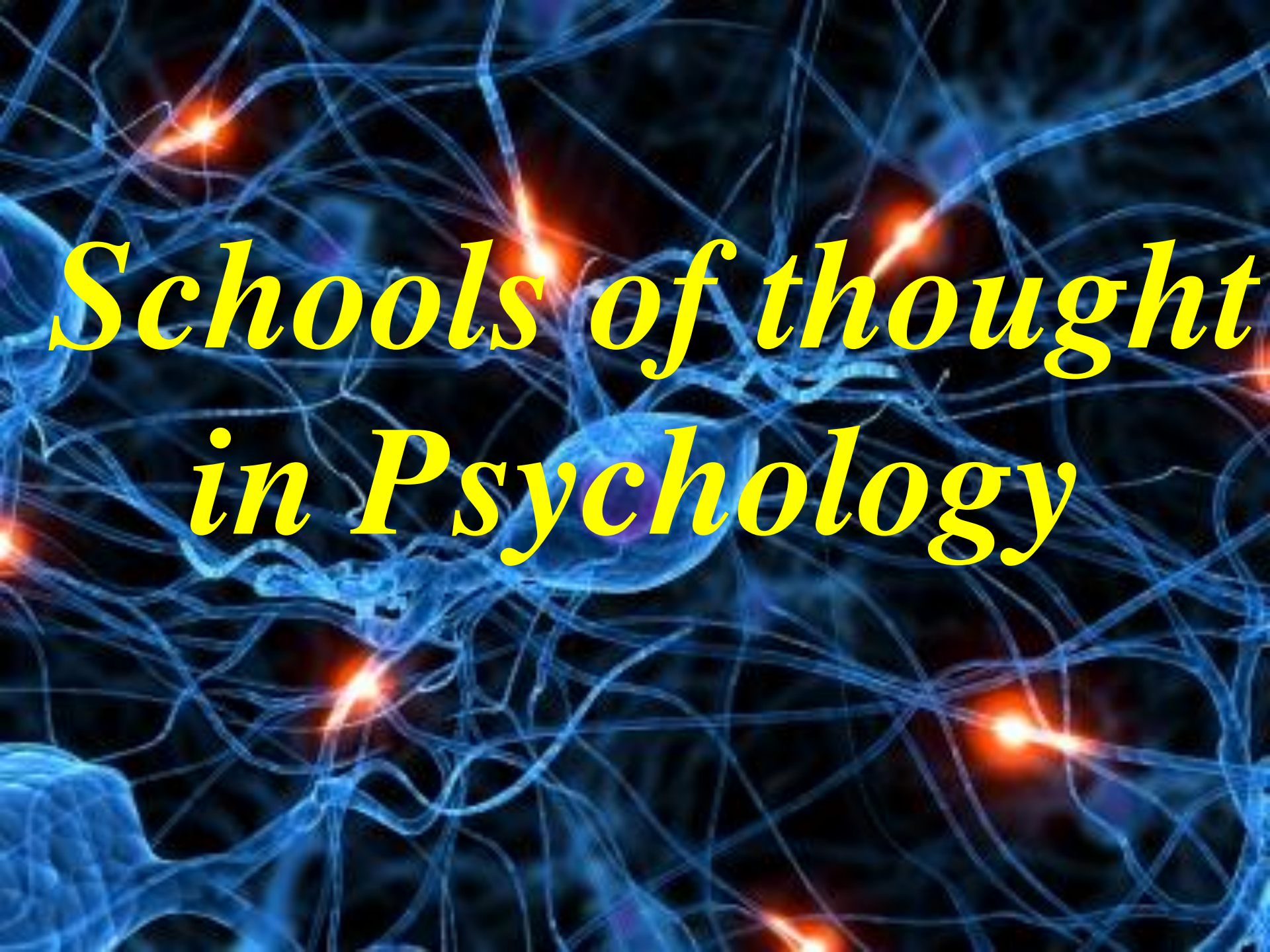
Public health is ‘ the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society’ (Acheson 1988).

Epidemiology means the study of disease distribution within a population.

Disease is the objective state of ill health, which may be verified by accepted canons of proof. Ex: microscopic analysis may yield evidence of changes in cell structure, which may in turn lead to a diagnosis of cancer or disease. Disease is the existence of some pathology or abnormality of the body which is capable of detection.

Disease prevention, an approach demanding a knowledge of medical conditions and an ability to assess and monitor disease trends.

- **Illness** is the subjective experience of loss of health. This is couched in terms of symptoms, for example, the reporting of aches or pains, or loss of function. Illness and disease are not the same.



Schools of thought in Psychology

**The following are some of the major school
of thought / perspectives in psychology.**

- **Biological**
- **Psychodynamic**
- **Behavioral**
- **Cognitive**
- **Humanistic.**

Biological psychology.

Biopsychologists are often accused of reductionism, which means they reduce the person down to their biological components so explanations of human or animal behaviour are said to be due to anatomy or physiological changes such as chemical reactions in the nervous and endocrine system.

Case Study : Mrs. Lillian Child.

Psychology by Sue Barker P.4.

Biopsychologists identify biological causes for behaviour and individual differences such as :

- Genes
- Anatomical differences
- Development through the lifespan
- Biological system such as : the nervous system, the endocrine system.

Endocrine system

The endocrine system is made up of glands that secrete hormones into the body. The major endocrine glands are shown in Table 1.1.

Biopsychologists study how each of these areas influence the behaviour of the person, in their search to understand that behaviour.

Endocrine glands and their principal effects. Adapted from Rosenzweig et al. 2005.

Gland	Principal effect
Pineal gland	Regulates seasonal changes and puberty
Hypothalamus	Regulates hormones released from pituitary gland
Pituitary gland	Produces a number of hormones which stimulate growth and development
Thyroid	Involved in metabolism and blood homeostasis
Adrenal glands	Regulates metabolism and body hair. Helps maintain blood sugar level
Pancreas	Involved in the metabolism of sugars
Gonads	Stimulate the development and maintenance of sexual characteristics and behaviour
Stomach	Involved in digestive processes
Heart	Promotes salt loss in urine

The biomedical model suggested that the cause of illness were outside the control of the individual: all physical disorders can be explained by disturbances in physiological processes, which result from injury, biochemical imbalance, bacterial or viral infections and so on. Psychology - little role in either health or illness and no relationship was postulated between the mind and physical illness (so-called ‘ Cartesian dualism’).

However, during the twentieth century there was a challenge to the biomedical model and the realization that a simple biomedical explanation for all illnesses is not sufficient (Engel, 1977,1980 cited in Rana and Upton 2009,p6).

Biopsychosocial model considers illness to be a result of a number of factors.

Bio

Viruses
Bacteria
Genetics

Psycho

Behaviour
Beliefs
Stress

Social

Class
Gender
Ethnicity

Neurotransmitters are the key information molecules of the brain.

Feed forward is the prediction of what is about to occur without waiting for feedback.

Feedback dynamics allow for modification of a behaviour while it is in progress.

Biopsychologists seek to understand behaviour from a biological basis, offering biological theories for human behaviour. They identify that people develop through a sequence of maturational changes as the nervous and endocrine systems develop. Nurses too seek to understand behaviour from a biological basis, regardless of the branch of nursing.

Behavioural change could be due to changes in the nervous system, endocrine system, or anatomical or genetic structure.

Psychodynamic psychology

This perspective was developed by Sigmund Freud (1858- 1939). A key component of his theory was around the inner or unconscious conflicts that motivate a person's behaviour. Freud said that all behaviour is meaningful and when people say things that are different from what they intended, their unconscious thoughts are breaking through to consciousness. Freud developed a structure of the mind, which includes three components: **Id, Ego and superego.**

Think

How would you explain the challenging behaviour of the patient?

There are a number of explanations such as being distressed, anxiety about what is wrong with them, problems at home, not being attended to immediately. All these answers result in a possible explanation of how previous experiences can influence current behaviour and thinking.

The psychodynamic approach explores how the mind (human psyche) , especially the unconscious part of the human mind is responsible for everyday behaviour. This is reflected in Morris and Maistow's (2002,p.445) definition of psychodynamic theory as:

Seeing behaviour as the product of psychological forces that interact within the individual, often outside conscious awareness.

The interplay of unconscious mental processes, determine human feelings, thoughts and behaviour.

Id – the biological and psychological drives that a person is born with constitute the id. It is the largest part of the unconscious structure of the mind.

Ego – the ego is the component of the personality that mediates the drives of the id with reality, in a way that promotes well-being and survival. This part of the personality or mind is the largest part of the conscious mind but at least half of it is preconscious.

Superego – it is often referred to as the conscience of the person, which is developed at about the age of five. The superego uses guilt and pride to facilitate compliance with social norms. The superego is partly conscious but also exists in the preconscious and unconscious. The superego is the component of personality concerned with moral behaviour.

The structural relationship formed by the id, ego, and superego is the accumulation of societal rules and personal values as interpreted by individuals. The superego emphasizes not reality, but the ideal, and its goal is perfection, as opposed to the id's pleasure or the ego's reality (Freud, 1935).

Conscious - the things we are able to become aware of if we attend to them. Conscious includes thoughts , feelings, and experiences that are easily remembered, such as current addresses, phone numbers

Left and Right Brain Functions

Left-Brain Functions

Analytic thought

Logic

Language

Science and
math

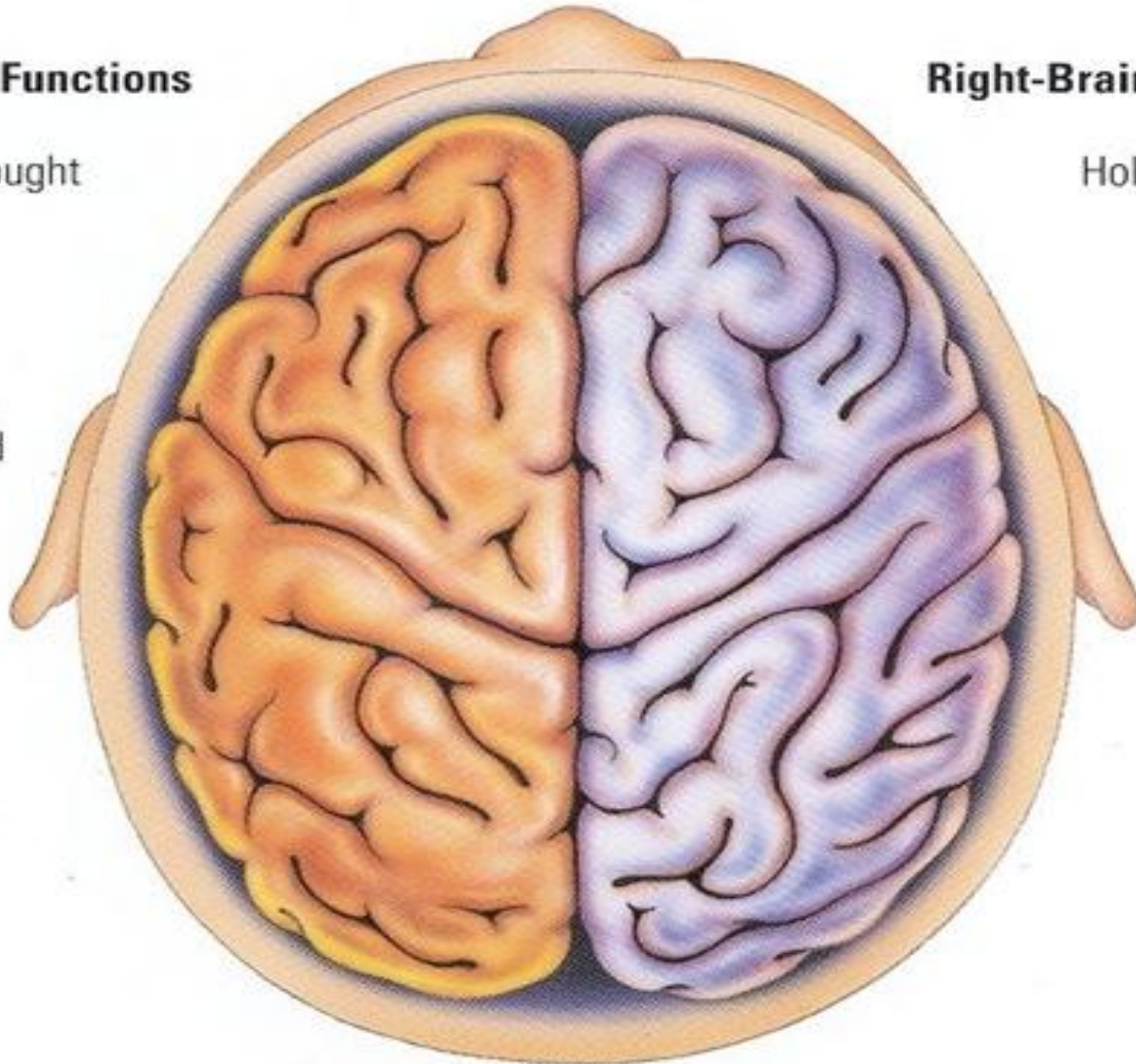
Right-Brain Functions

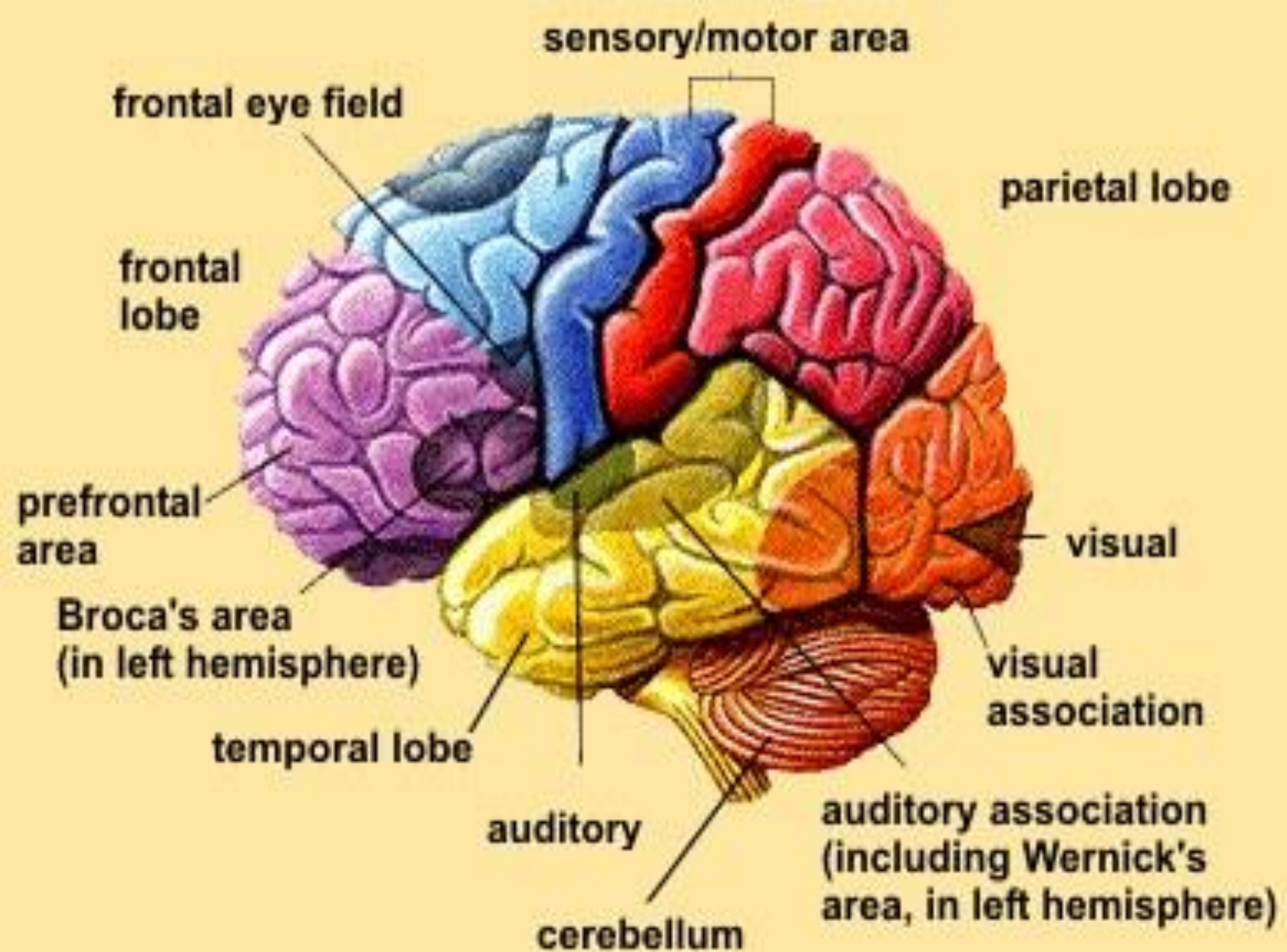
Holistic thought

Intuition

Creativity

Art and
music





There is a further aspect of Freudian theory called consciousness, which has **three levels**: the preconscious, the conscious and the unconscious.

Preconscious — (sometimes called subconscious), includes thoughts, feelings, and experiences that have been forgotten but can easily be recalled, such as old phone numbers or addresses, the feeling a woman had during the birth of her first child, the name of a first boyfriend or girlfriend.

The unconscious – to the things that we are not normally aware of. It encompasses thoughts, feelings, experiences, and dreams that cannot be brought to conscious thought or remembered (Freud, 1935). The three aspects of personality, the id, the ego and the super-ego, operate below conscious level, although the ego and super-ego are partially in the conscious level.

Freud suggested children are born with the id but develop the ego and superego through psychosexual developmental stages. These experiences in early childhood have a strong impact on later personality.

Freud's stages of psychosexual development are:

- Oral 0 -18 months
- Anal 18-36 months
- Phallic 3 – 6 years
- Latent 6 years to puberty
- Genital puberty onwards.

Stages of Psychosexual Development according to Freud

Characteristics.

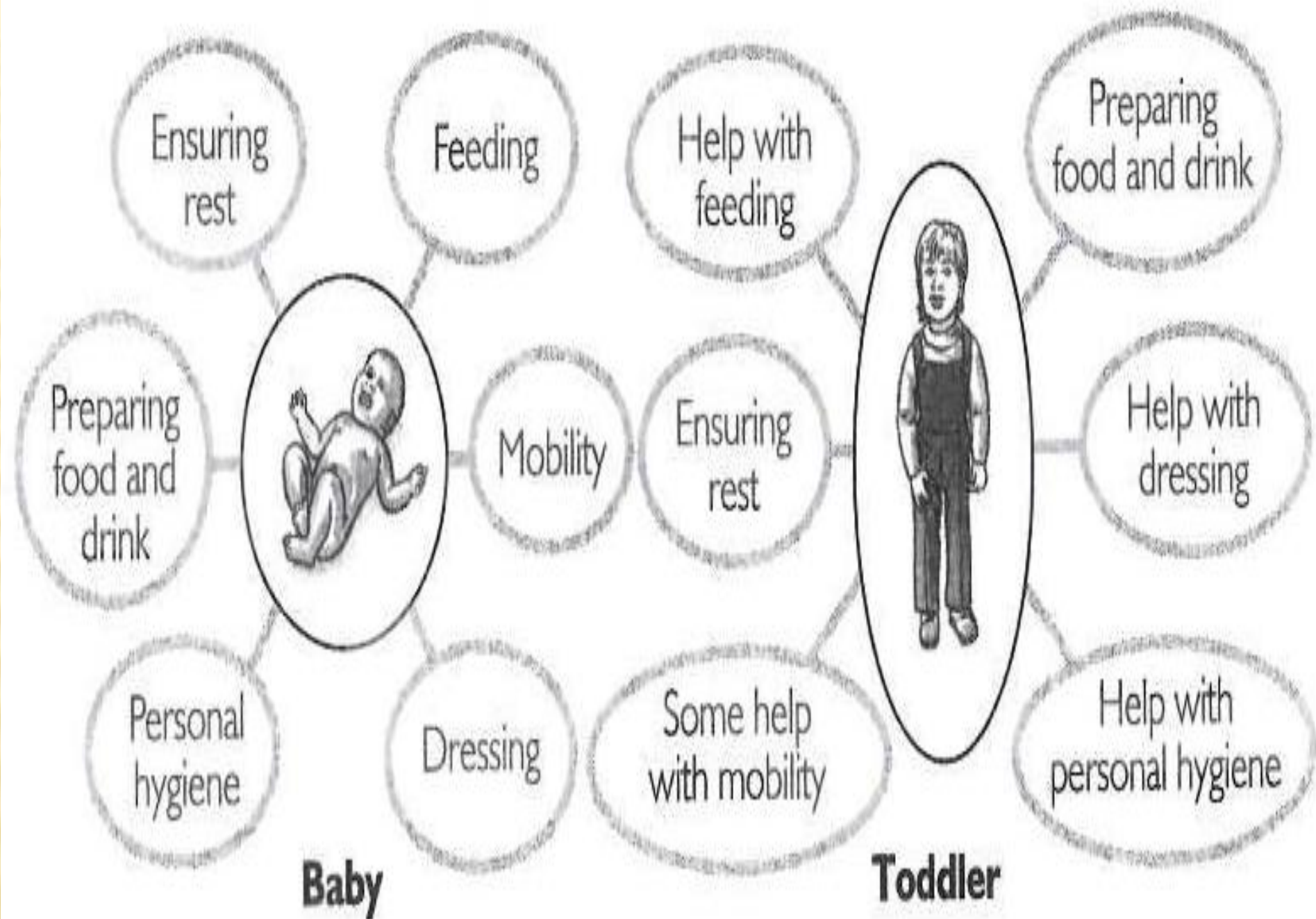
Oral – Principal source of pleasure from mouth, lips, and tongue. Dependent on mother for care, so feelings of dependency are developed.

Anal - focus on muscle control necessary to control urination and defecation. Expulsion of feces gives a sense of relief. Learns to postpone gratification by postponing the pleasure that comes from anal relief.

Phallic – Develops an awareness of the genital area. Sexual and aggressive feelings associated with functioning of the sexual organs are emphasized. Learns sexual identity during this stage. Masturbation and sexual fantasy are common.

Latency - Sexual development dormant. Focus of energy on cognitive development and intellectual pursuits.

Genital - Abundance of sexual drive. Primary goal is to develop satisfying relationships with members of the opposite sex.



Help in
ensuring rest



Some help
with personal
hygiene

Help with
preparing food
and drink

Child/adolescent

Relief
of pain

Mobility

Personal
hygiene



Preparing
food and drink

Eating

Dressing

Older person

It has been suggested that the most important of these psychosexual stages is the phallic stage; this is where the child experiences either the Oedipus or Electra complex and where the superego or conscience starts developing. It is where the child becomes aware of their own gender and a rivalry develops towards the same sex parent to compete for the affection of the opposite sex parent.

Boys and girls resolve this in different ways; the boys identify with the father due to fears the father will castrate them.

Summary

Freud offers a psychodynamic theory of the mind, personality and its development. It is a psychosexual theory, which has a number of stages of development. Freud identified the impact that these stages have on the personality and offered mechanisms that the person would use to manage the continuous internal conflict of the different components within the mind. This perspective offers the nurse a completely different way from previous biopsychologists to understand the people with whom they work and themselves. It demonstrates how a person's childhood may have influenced their personality and that this personality rather than being totally fixed is always in a state of movement and tension. It also offers an approach for understanding reactions to health problems that they may experience.

It demonstrates how a person's childhood may have influenced their personality and that this personality rather than being totally fixed is always in a state of movement and tension. It also offers an approach for understanding reactions to health problems that they may experience.



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Globalization

Introduction.

1950 -

The origin -

1980

The process -

Some Aspects of Globalization.

1402

Economic Globalization.

Harry Markowitz 25/11/1950 -

1424

The first world.

The second world -

The third world -

The fourth world -

Globalization in International Regime.

1455

Political Structure - -

2304

How you heard about accountability?

2014

Professional nurses needs to become accountable.

b.

1500

A student is accountable for his own learning -

do some reading about accountab

* At ^{LO} the end of the session, the student will be

able to: > Discuss the concept

> Describes the basic rights & responsibilities of a

professional nurse.

* Reflect on the standard

Definition:

1. The ability and willingness to assume responsibility for one's actions and accepting the consequences of one's behaviour". (Fundamentals of Nursing; Concepts, Process and Practice: Kozier, Erb, Blaus Wilkinson, Addison Wesley, 5ed. PL410.

2.

3.

4. The responsibility and answerability of ones actions or omissions, omissions.

we are accountable for our decision & indecision -

NURS

JAYBERG.

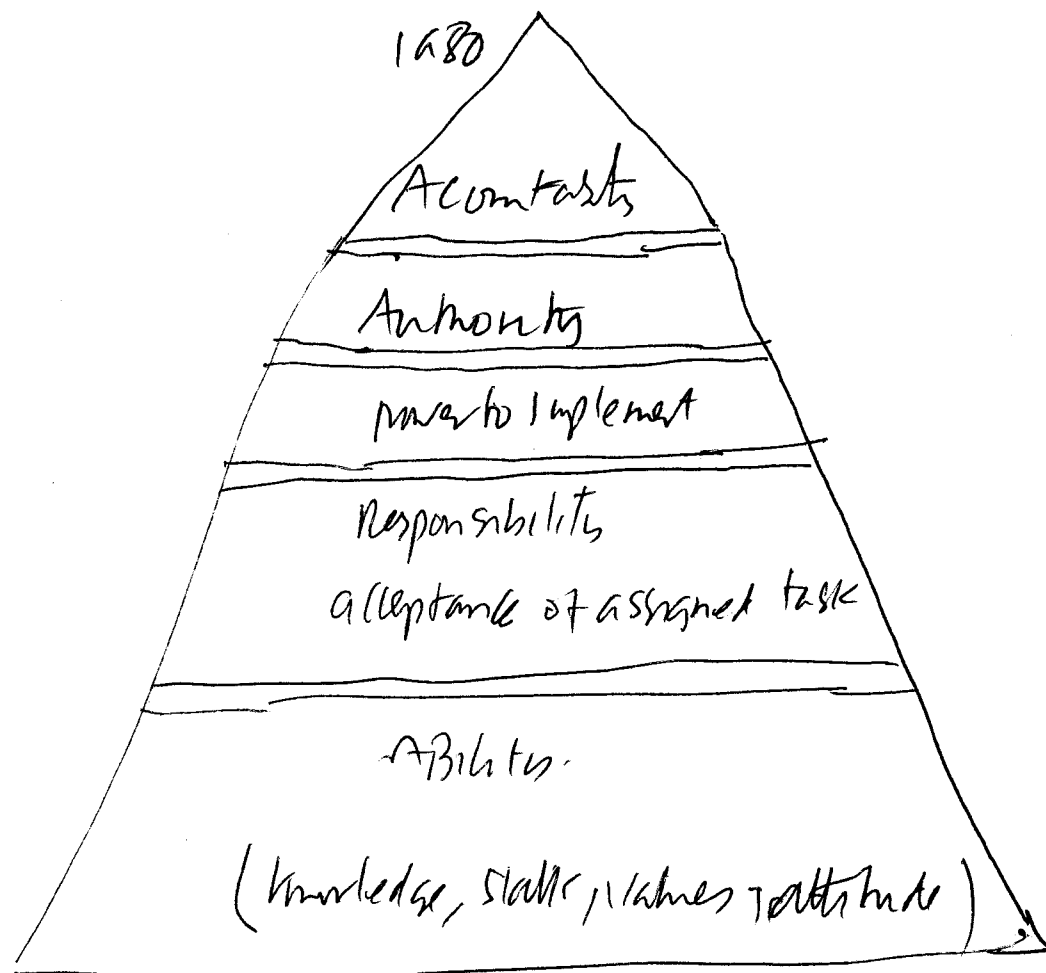
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Pre conditions for Accountability

REBECCA BERGMAN

1980



1518

⚠ Push, sound, External, extrinsic factors or societal factors

1: The rising cost of health.

2: Competition.

⚠ Internal (intrinsic) or "pull" professional factors.

1: Professional requirement -

2: Higher education in nursing -

3: Life long learning culture:

ps 26.

This week meeting with Concellen on a group -

320 public 11 -

8

Semester 1

Year 4

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2014
1310

Levels of Proficiency

from novice to expert

An American nurse did research on how

learner's nurse work.

LEARNING OUTCOME

At the end of the session, students will be able to:

Share
work &
Study

△ Illustrate Benner's levels of proficiency -

- All Nurses are not competent.
- Some nurses are not competent at all.
- All competent nurses are not equally competent
- Some nurses are more competent than others
- Few nurses are very very competent.
- Very few nurses are very competent: experts!
- What are the different levels of competency?
- What is needed to climb the competency ladder?

Patricia Benner (1984)

- Studied & described the stages of skill acquisition in

Nursing

- Skill acquisition is SEQUENTIAL: from the stages of competence
- 5 stages of skill acquisition.

13:18

Semester 1

(1)

XEP2

11/11/001

2304

2014

* Advanced begins demonstrate marginal

acceptable performance because he understands an a prior

appears competent in actual situations.

+ Knowledge is developing.

* He/she is skilful in parts of the practice area.
Requiring occasional supervision and guidance.

* Has some basic knowledge about the job

* Cannot practice on his/her own

Competent Practitioner.

* Competence is demonstrated by the nurse who has been

in the job with similar situation for two or three years

* Nurse plan & perform patient's care after much
analysis of patient problems.

* Has authority but authority compromised due to
lack of own experience

* Nurse is confident & can practice independently

* Having ^{the} knowledge & experience to

Proficient Practitioner

2304
2014
* Perceives Situation as a whole (holistically)
rather than parts

* Has high experience of self guidance in
difficultly practical situation.

* Uses Reflexive Skills — * Reflection on Action
Reflection in action (to reflect
on past action during a
similar action)

* state of excellent Excellence.

Reflection on Action.
EXPERT PRACTITIONER

* Expertise is the perceived highest state of skill
acquired in a particular field by someone.

* Expert operate from a deep understanding of
the total situation by taking a holistic view. Sees the
big picture

* Intuitive

* Intuition is having the ability to make the right decision
at the right time without having recourse to any rational
(reasoned) analysis in a sequential way - (anecdotal)

CRITERIA OF A PROFESSION

- Unique body of knowledge
- Special education
- Has a regulating body
- A code of ethics regulating practice
- Beneficial for public & practitioner
- Autonomy for practice
- Accountability
- Expertise

PROFESSIONALISM

Definitions:

- "the skill or qualities required or expected of a member of a profession"

Oxford dictionary(1992)

- "Professionalism is often associated with professional behaviour, that is a concept of behavioural practice which can be considered 'professional' regardless of that the fact the occupation may not feature as a professional entity"

Cook, 1992)

CHARACTERISTICS OF NURSING AS A PROFESSION

- Has a systematic body of knowledge
- Work as specialist/expert at advanced level
- Autonomy
- Responsibility & accountability
- Requires advanced education
- Remunerated
- Self-regulation (Nursing Council of Mauritius)
- Has a code of professional conduct
- Professional image (uniform, language, jargons & values specific to Nursing)
- Altruism (service for others)

ROLES OF A PROFESSIONAL NURSE

- Royal College of Nursing (RCN)

1. To promote and maintain health.
2. To care for people when their health is compromised.
3. To assist recovery.
4. To facilitate independence.
5. To meet needs.
6. To improve/maintain well being/quality of life.

ROLES OF A PROFESSIONAL NURSE

- International Council for Nurses (ICN)

1. To promote health
2. To prevent illness
3. To restore health
4. To alleviate suffering

PROFESSIONALISM OF NURSING

Profession	Full-time occupation	First training school	First University
Medicine	1700	1765	1779
Law	17 th century	1784	1817
Nursing	17 th century	1861	1909

BARRIERS TO NURSING PROFESSIONALISATION

External (extrinsic) factors

- Historical influence of church
- Nursing education level
- Medical dominance

2. Internal (intrinsic) factors

- Female dominance
- Lack of assertiveness

CONCLUSION

- Nursing is well established as a profession
- Unlike other professions, Nursing has struggled a lot to attain the status of a profession
- Nursing has faced barriers to professionalism
- Multiple roles of a professional Nurse
- Nursing also takes a vocational dimension due to its altruistic nature
- Values makes nursing a noble profession

ADVANCED BEGINNER

- Advanced Beginners demonstrate marginally acceptable performance because the nurse has had prior experience in actual situations.
- Knowledge is developing.
- He/she is skilful in parts of the practice area, requiring occasional supervision & guidance.
- Has some basic knowledge about the procedure & situation
- Cannot practice on his/her own
- Mentors are needed

COMPETENT PRACTITIONER

- Dictionary definition: "Having the qualifications required by law."
- Nurse is confident & can practice independently.
- Has authority but autonomy compromised due to lack of rich experience.
- Nurse plans patient care after much analysis of patient problems
- Competence is demonstrated by the nurse who has been on the job in the same or similar situations for two or three years.

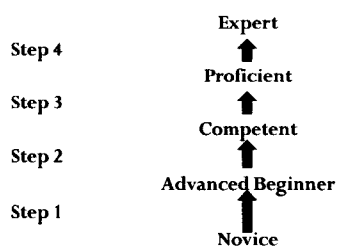
PROFICIENT PRATITIONER

- Perceives situation as a whole (holistically) rather than parts.
- Has rich experience for self-guidance in difficult practical situations.
- Uses reflective skills
 - Reflection on action (to reflect on a past action)
 - Reflection in action (to reflect on a past action during a similar action)
- Independent/autonomous & confident.
- State of excellence.

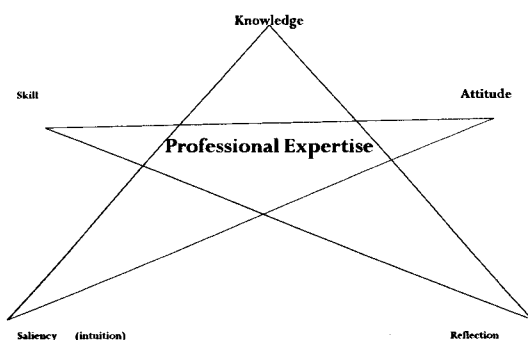
EXPERT PRACTITIONER

- Expertise is the perceived highest state of skill acquisition in a particular field by someone.
- Experts operate from a deep understanding of the total situation by taking a holistic view. Sees the big picture
- Intuitive
- Intuition is having the ability to make the right decision at the right time without having recourse to any rational (reasoned) analysis in a sequential way

THE 5 STAGES



A CONCEPTUAL FRAMEWORK FOR EXPERTISE (RCN)



CONCLUSION

- Benner described 5 stages of skill acquisition
- Nurses need to know these stages to assess & measure progress of self & others
- We need the following to move from novice to expert:
 - Knowledge
 - Skill
 - Attitude
 - Reflexivity
 - Wisdom
 - Time
 - Intuition

REFLECTION

- To reach expertise is a vision.
- Learning to move towards Expertise is a mission.
- To stabilise at Expertise level is an illusion.

*Because
"there is always more we'll never know
than we'll ever know"*

NURS

A conceptual framework for Expertise.
(RCW)

Jayseeg

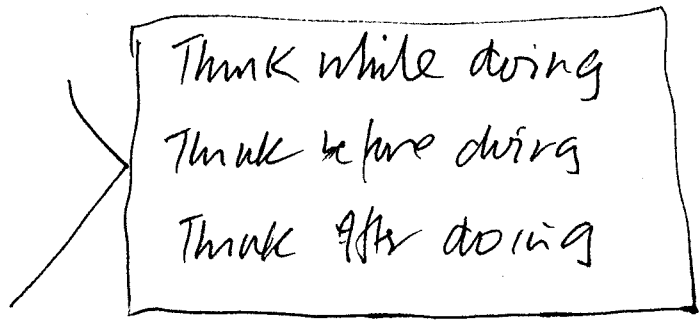
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- △ we don't need hard workers.
- △ we need smart workers

Methodology

1440

3



3T

- 2 How to improve practice? work on it as increments - work on Action - in action -

Schon

To reach expertise is a vision

Learning to move towards Expertise is a mission

To stabilise at Expertise level is an illusion

Because.

"There is always more w 'll ever know than we
ever know"

NURS

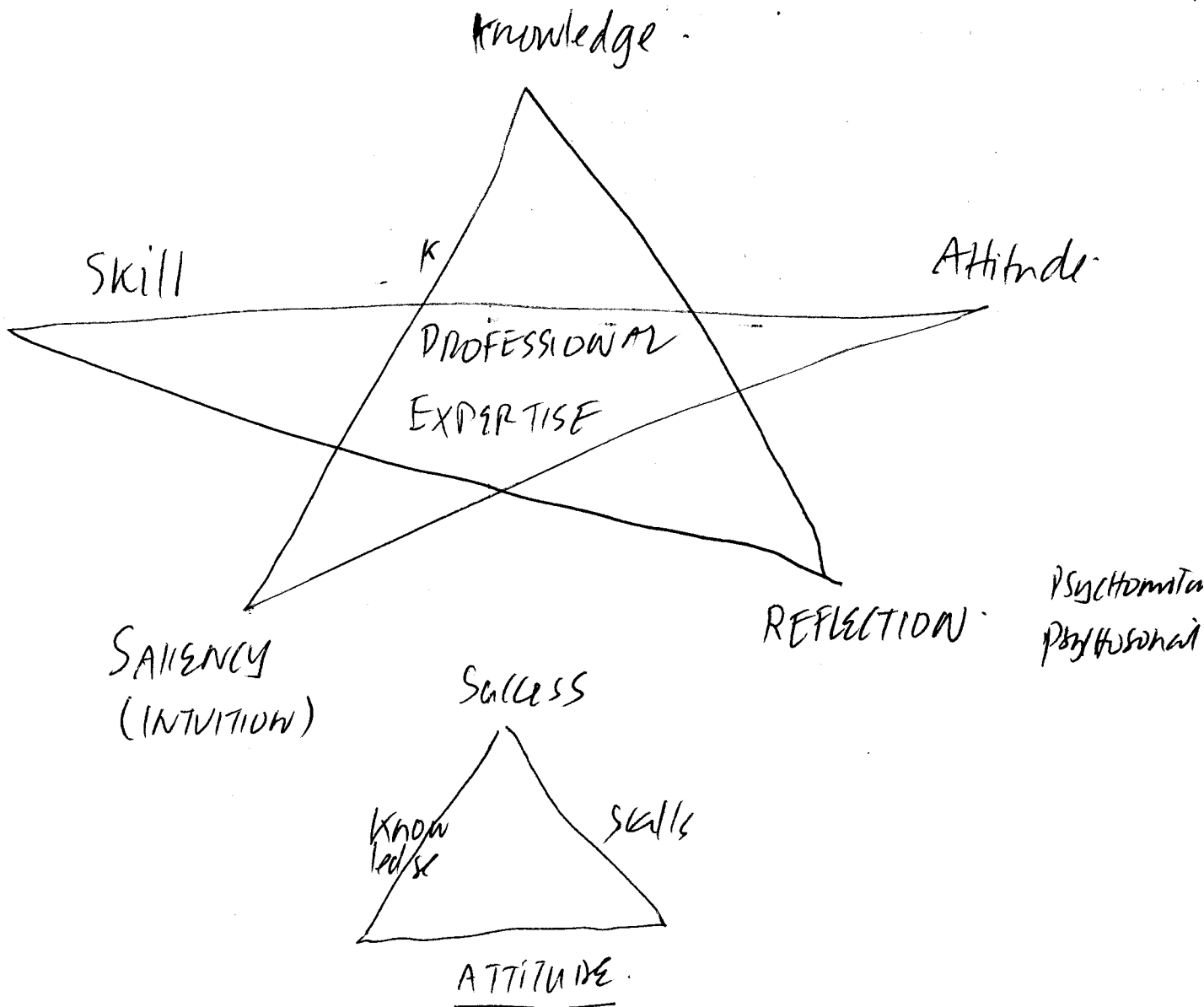
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JANSEEL

A conceptual Framework For EXPERTISE (RCS)



— CONCLUSION —

* Benner described 5 stages of skill acquisition

* Nurses need to know these stages to assess a measure progress & self-reflection

* We need the following to move from novice to expert:

- ☐ Knowledge ☐ Skill ☐ Attitude ☐ Reflexivity ☐ Wisdom
- ☐ TIME ☐ Intuition ☐

GOAL OF NURSE IN ETHICAL DECISION MAKING

- The goal of the professional Nurse is to help the parties involved to respect each other's values and to help individuals prioritise their values and preserve the most important ones in the process of decision making (Fry, 1989)

Posted: Feb 8, 2005 12:35 AM

"Power Shift," Jessica Matthews: This article discusses the rise of civil society and relative decline of states since the Cold War, largely as a result of new technologies and communication systems that enable widespread access to and interchange of information. Today's NGOs rely on rapid communications systems to bring national attention to their respective causes, particularly in cases where states have violated international norms. NGOs have grown considerably in past decades, delivering, "more development assistance than the entire U.N. system (excluding the World Bank and the International Monetary Fund)" [53]. NGOs both contribute to the setting of policy agendas and the implementation of policy. They provide the advantage of responding more rapidly than governments to challenges. This article provides an interesting perspective on the evolution of NGOs as a predominant force on the international scene, but does not get at some of the potential problematic issues associated with their emergence.

"The Idea of Global Civil Society," Mary Kaldor: Kaldor defines civil society as, "the process through which individuals negotiate, argue, struggle against or agree with each other and with the centres of political and economic authority" [585]. Over time, civil society has evolved to this definition from a time when it included the state. Kaldor asserts that civil society achieved a revival in the 70s and 80s in Latin America and Europe, where groups frustrated by severe state regimes found support from international organizations and newly arising human rights legislation. In the 1990s, numerous social movements sprung up (human rights, environment, etc.), and NGOs became increasingly powerful, even taking on some state roles. Kaldor believes that the U.S. war on Iraq presents a threat to the emerging global system described, but does not believe Bush's actions will derail the process. While the arguments presented are compelling, I would have liked the article to explore more fully the implications of direct state interventions, or what the article refers to as "international relations" as opposed to global systems. The article appears to condemn the Iraq war, but would the author similarly condemn the U.S. government unilaterally sending forces into Darfur to end the genocide?

"Worlds Apart," John D. Clark: This article describes the dramatic increase of civil society organizations in past decades, and addresses many of the challenges faced by NGOs and CSOs in responding to many and varied international demands. It discusses some of the strategies employed by big-name NGOs and their relative advantages (ie. international organizational consistency vs. local office issue flexibility). Organizations that effectively utilize information, symbolism, leverage, and accountability have been proven successful. The article also responds to widespread critics of the World Bank by downplaying the Bank's influence in the international arena and asking that both the U.S. and developing countries' governments be held accountable for their actions as well. Finally, the article addresses the growing trend of less centralized and more networked N-form organizations, which promote enhanced information exchange.

"Social Movements and World Politics", Smith, Pagnucco & Chatfield: This article explores the value of transnational social movements and their role as compared to IGOs. These movements fill an important gap as implementers, where IGOs often fall short (assuming more the decision-maker role). They also serve to grab the public's attention quickly and internationally, drive change rapidly through informal professional and friendship networks, provide valuable technical insight to governments, and work to promote government accountability and transparency through monitoring and advocacy.

"Civil Society and the Future of the Nation State": This article explores the potential dangers of the rise of civil society and the weakening of government power in favor of private interests. Threats include the potential ascendancy of single-issue activism, unruly or malevolent groups assuming power, and

	weakened democracy (as private interests do not report to individuals beyond their own constituencies). An additional issue the article could have addressed would be the influence that international organizations have on the local politics of developing countries. The question of democracy becomes even more critical when “civil society” represents foreign interests in national decision-making.
--	---

THE NIGHTINGALE PLEDGE

composed by Lystra Gretter

- I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the course of my practice with loyalty and discretion. I will be true to the work, and devoted to the community I am committed to.

ETHICAL DECISION MAKING

- Nurses being professionals have the responsibility & are accountable for making decisions that are ethical so as to protect the client, public, the hospital, the profession & themselves
- Ethical decision making is an inexact process
- There is no secure & definite action
- To make ethical decisions, a tool (framework) is helpful

IDENTIFY THE PROBLEM

- State the problem clearly
- Is there any ethical issue?
- Do 2 or more values or principles appear to be in conflict?

GATHER DATA

- What is the history?
- Who are the main people involved?
- What are their views & interests?
- What is the patient's situation?
- Any legal implications?

IDENTIFY OPTIONS

- What are the possible *courses* of action?
- What are the probable *impact* of each course of action?
- What future decisions *are likely* to come up for each option?

MAKE A DECISION

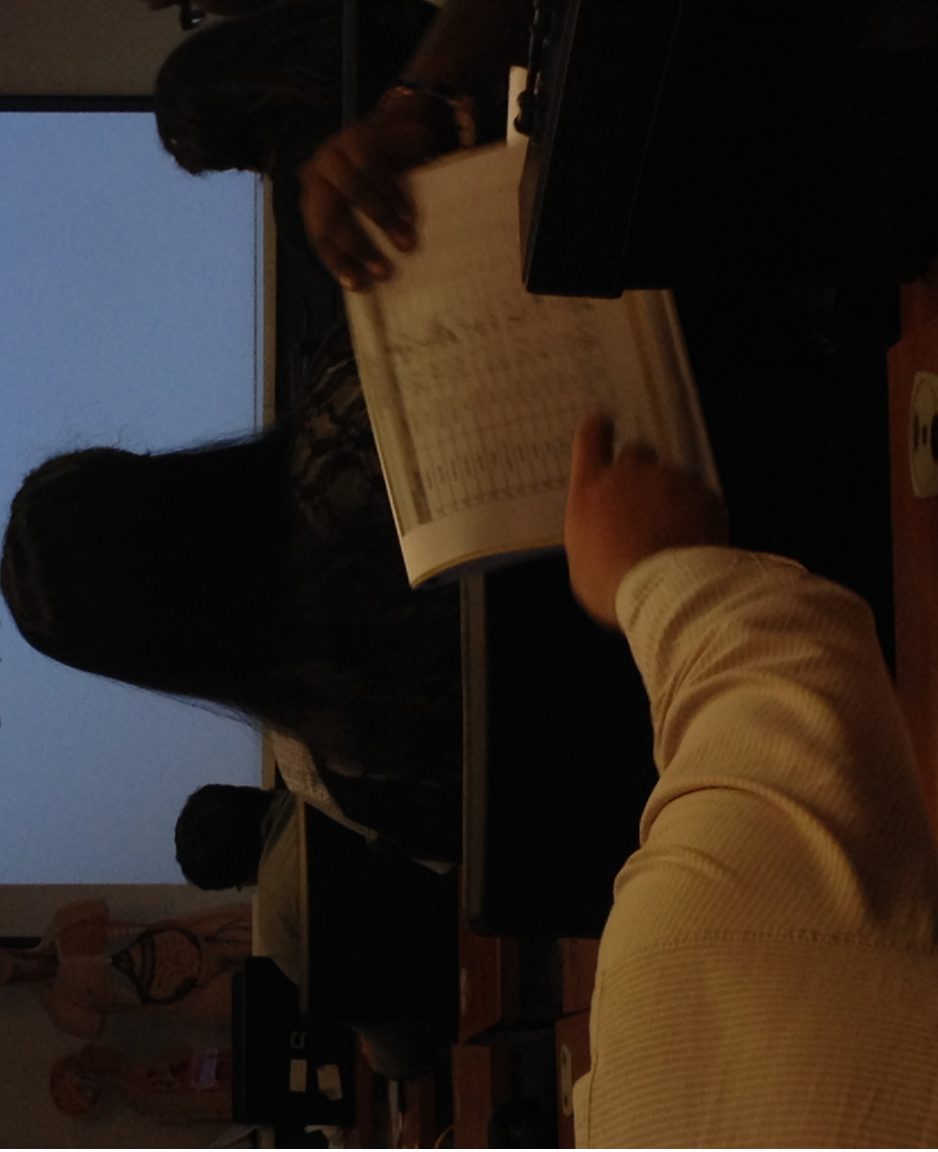
- After carefully considering controversial issues, choose a course of action based that best reflects your judgement
- Discuss with other health care staff & your manager
- Present your course of action as "our choice"

ACT & ASSESS

- Carry out the chosen that may be full of surprises
- Compare the actual outcome with your expectation
- Consider how you can improve the decision process next time

GOAL OF NURSE IN ETHICAL DECISION MAKING

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GOAL OF NURSE IN ETHICAL DECISION MAKING

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11/08/2014
Deputy Chief
Nursing Officer
of BBH -
Wrexham.

16-04-2014

NURSING-MANAGEMENT
&
EDUCATION

Content -

Mac
See also
IS.
DCND
5 credit

Chief

Nursing as a profession

ethical aspect of Nurs.

Criteria of a profession -

levels of professionalism -

Concept of professional accountability

Elements of professional accountability -

Adult
pedagogy

* Prescribed learning outcome - Cognitive -

At the end of his term - he should

have known -

* Teaching methods - Lectures -

- Group work -

Collective answers

* Formative assessment - @ Module exam -

1045.

Chapter 10	The Legal Context of Nursing <i>Ellen Murphy</i>	193
Chapter 11	Gender Issues in Nursing: A Global Perspective <i>Sandra Speedy</i>	209
Chapter 12	Becoming Part of a Multidisciplinary Health Care Team <i>Kathleen M. Nokes</i>	231
Chapter 13	Professionalism: The Role of Regulatory Bodies and Nursing Organizations <i>Vickie A. Lambert and Clinton E. Lambert</i>	245
Chapter 14	Public Health Nursing: An Exercise in Citizenship <i>M. Katherine Maeve</i>	257
Chapter 15	Rural Health in America: Challenges and Opportunities <i>Catherine Reavis</i>	275
Chapter 16	Meeting the Health Care Needs of a Diverse Society <i>Akram Omeri and Margaret M. Andrews</i>	295
Chapter 17	Critical Thinking in Nursing: Beyond Clinical Judgment to Perspective, Context, and Meaning <i>William K. Cody</i>	317
Chapter 18	Making the Transition to Professional Nursing: Becoming a Lifelong Learner <i>Jane Conway and Margaret McMillan</i>	335
	<i>Index</i>	347

Professionalism: The Role of Regulatory Bodies and Nursing Organizations

**Vickie A. Lambert and
Clinton E. Lambert**

LEARNING OBJECTIVES

After completing this chapter, the reader should be able to:

- Describe regulatory authority
- Discuss the role regulatory authority plays in the protection of the public
- Discuss the role and mission of select major professional nursing organizations
- Delineate the benefits of membership in professional nursing organizations

KEY WORDS

Regulatory authority, licensure, boards of nursing, nurse practice act, professional nursing organizations, accrediting agencies

INTRODUCTION

Regulatory bodies and professional organizations play a vital role in the maintenance and enhancement of professionalism in nursing. It is

Writing Nursing Reports

Writing reports is an essential skill. The skill requires a knowledge of a lexicon and rules of grammar to govern that lexicon.

Experiment and explore. otherwise modify for a particular purpose any concept that you don't understand, or need to understand more precisely, or have forgotten.

The 3gtic rules

Generative Grammar Noam Chomsky

NURS1008

16-04-2014

JaySeeg

Devo

☐ Critically select one definition of
Nursing — explain why —
History of Nursing

What nursing means to you?

How would you define nursing?

History of Nursing

☒ Ancient Rome.

> Temple hospitals & Roman noblewomen were Nurses

> Europe 10-15-1271- Crusades (religious wars)

1st Hospital in Jerusalem

1st Nurses: the knights of St. John (men)

☒ Late Middle Ages.

> Soldiers returning home

> Political mechanism — Healing skill —

3004

Why ethics & morality is important?

Ethics is the discipline with what is good and bad or right and wrong or with moral duties and obligation.

* Reflect in small group on the concept of ethics

* Compare legal & ethical concepts

* Describe the major ethical principles that affect health care; identify examples that relate to each.

* Analyse situational complication applications of the provisions of the code of ethics for Nurses.

* Utilise ethics-moral principles as guide in resolving problems in Nursing practice.

* Use the framework for ethical decision-making in facing an ethical dilemma.

INTRODUCTION

* Nurses make decisions & take actions all the time

* Some decisions & actions are simple & straightforward

1407. > Example: Patient asks for a painkiller, nurse administers the prescribed medication

▷ Some decisions can be influenced by:

3004

> Patient's personal & cultural values

1410

> Nurse's personal values & professional values/responsibilities

> Example: Terminally ill patient wants to smoke.

A moral dilemma.

Ethics, ^{which} is a branch of philosophy helps to understand & sort out moral dilemma's.

$$E \sum \begin{pmatrix} E & M \\ D & I \end{pmatrix} \int_{I+}^{B-} f(x) (\text{Legal}) \sim$$

DEONTOLOGY.

$$\left\{ \begin{matrix} B \\ \end{matrix} \right\} \quad M+E = m+\bar{E}$$

$$D = D$$

$$D-E = D-E$$

$$D-E-C-T = D-E-C-T$$

$$D-E-C-T+T+C+E = D$$

$$R+D+G = R+D+G$$

$$D+R = D+R$$

$$R = -D+D+R$$

$$QD+QNP+MR = 99$$

$$C = C$$

greatest good - greatest no. of people - majority rule

$$99 = 99$$

15-11

NUR 5100

3004

2014
~~1410~~

1512

CONSEQUENTIALISM

D & C

Deontology & Consequentialism

U.A = Universal rules.

C = Consequence & Action —

1. Deontology rules are followed.
2. Consequentialism where the right the ethical ones tend to be right of the majority

Ethical Principles

Autonomy

Tool to solve moral Dilemma

Non-maleficence

Beneficence

Justice

Veracity

Fidelity

Ethical principles can help to clarify the decisions that have to be taken at work.

AUTONOMY

Ethical principle that obliges one to allow individuals to self-determine their own plans & actions. It entails respecting the personal liberty of individuals & the choices they make, based on their own personal values & beliefs given that they have been provided with all relevant information & knowledge.

INFORMED CHOICE

Semester 1

Y51021

Nurses / 00

Sang

It refers to a person's ability to choose freely for themselves & be able to direct their own life

❑ Not everyone has autonomy

> People with learning difficulties

> Mental illness

> Young children

> Older people with Alzheimer's - 10

❑ Powers of attorney =

Autism = - dependencies

No Test on Friday - The word MORAL

Ethical aspect of Nursing -

Look up MORAL on Friday -

OL05-
2014.

VERACITY

1: The obligation to tell the truth & not to lie.

Truthfulness commands respect & builds a good nurse-patient relationship.

2: Not telling the truth is not the same as lying.

A nurse can withhold an informant when not asked.

3. Veracity as a virtue

4 Fidelity # obligation to remain faithful to one's commitments towards self, clients, colleagues & organisations

CODES OF ETHICS

TYPES OF VALUES

MORALITY

Morality is a system of ideas of right & wrong

Ethical decision making

02-05
2014

- 6.1 Autonomy
- 2 Non-maleficence -
- 3 Beneficence

- 4 Justice
- 5 Veracity
- 6 Fidelity

2 (-) ^{Do no harm -} obligation to avoid harm - provide sterile needles by hand

- △ Risk assessment for potential harm;
- > Side effects of medication
 - > Pain related to a procedure
 - > Possible complication of surgery
 - > Anxiety & stress related procedures.

△ Nurse decision must not produce harm to patient -).

3 * Beneficence - Doing or promoting good as well as preventing, removing a crisis and or harm.

* The obligation to do good.

* Nurse must inform the patient that the aim of any action taken is for his/her benefit.

4 Justice # Justice requires that people are treated equally.

* Equality - ^{EQUITY -} equivalent ^{EQUALITY -} always to need at

equal unit

* How nurses allocate time to patient.

Numb/008

02-05

12

$$GDN = GDN$$

$$GDN - 3 \text{ week (3w)} = GDN - 3 \text{ weeks (3w)}$$

$$GDN - (3w) = GDN - (3wF)$$

— ①

$$GDN + \text{Psychology (Psy)} + \text{Management (M)} + \text{Education (E)} =$$

$$GDN + \text{Psychology (Psy)} + \text{Management (M)} + \text{Education (E)}$$

— ②

$$GDN + (Psy) + (M) + E = GDN + Psy + M + E$$

— ③

$$GDN + Psy + M + E + \text{BLS} = \text{Basic Life Skills (BLS)} =$$

$$GDN + Psy + M + E + \text{Basic Life Skills (BLS)}$$

$$GDN + Psy + M + E + BLS = GDN + Psy + M + E + BLS$$

— 4

$$GDN + Psy + M + E + BLS \neq \text{Nursing Theory \& Practice (NTP)} =$$

$$GDN + Psy + M + E + BLS + \text{Nursing Theory \& Practice}$$

$$GDN + Psy + M + E + BLS + \text{NTP} = GDN + Psy + M + E + BLS + \text{NTP}$$

— 5

$$GDN + Psy + M + E + BLS + \text{NTP} \neq$$

$$GDN + Psy (\text{Dingy P} + \text{Great (sf)}) + M + E + BLS + \text{NTP} =$$

$$GDN + Psy (P + sf) + M + E + BLS + \text{NTP} = GDN + Psy (P + sf) + M + E + BLS + \text{NTP}$$

16-04-2014.

JAYSEE
DENO?
— P.T.

Nursing Management

&

Education 1
— 98Learning
process
with
staged -
learning
stage
—
Adult
redesign.

Nursing is a very large collection of concepts

1054 Such as, Society, environment & health. #

, Value. {personal / corporate.}

* Principles or standards of behavior. One's

Judgement of what is important in life.

Oxford Dict.

* Important & lasting beliefs or ideas about what's

Good or bad & desirable or undesirable.

* Values have major influence on a person's

behaviour & attitude & serve as a broad guideline
in all situations.

Respect is a core value. CRUK-12

Values have influence on person at work. -

Nursing Management
^
Education

Jan 25

● Catholic Church (10th - 16th Centuries).

- > Advocated that the art & science of caring was a vocation - a calling from God -
- > Nuns as Nurses help the sick, injured & poor
- > Reform in Nursing based on Shaftesbury observations

Marked a female heritage (Florence Nightingale & her own vision)

- > England
- > Elizabeth Fry (1780-1845): Pioneering Nursing
- > Florence Nightingale (1820-1910): Sentinel & Turkey

1118

The mind goes in the past to look at the
togetherness; it goes in the future ^{to} look at the
problems -

Life in today, now - the past is good,
the future will always be in the future even -
the present - so focus on the present -

Basic Nursing

Compassion

Nurs/008

16-04-14.

Nursing Management

Education 1

Exploring definition of Nursing

Subleg

VB 10%

Ref Hnt

Remarks

o Lay definition

o Professional definition

o

o

= Suckling an infant

= A female servant who takes care of the sick ^{of the sick}

= Doctor's Assistant

= follows health instructions

= A person who takes care of the sick or wounded.

② OREM (1985) "Nursing is deliberate action to

bring about humanly desirable conditions in persons and the environment.

③ V.H (1961) "The unique function of nurses is to

assist the individual, young or old, in the performance of those activities contributing to health or its recovery (or prevent disease) that he would perform unaided if he had the necessary strength, will, knowledge, etc. and to do this in such a way to help him to regain independence as soon as possible.

Nursing Theory and Practice I

Introduction to Nursing:

- Supervised Clinical Observation
- Nursing Science
- Nursing Care of the Patient
- Basic Nursing Care and Needs of the patient

First Aid:

- Introduction
- Importance of first aid and rules of first aid
- Concept of emergency
- First Aid in Emergency situations
- Community Emergencies and Resources
- Community Emergencies

Personal Hygiene:

- Introduction
- Concept of Health and its relation to successful living
- Maintenance of Health
- Physical Health

Nutrition:

- Introduction
- Classification of food
- Normal dietary requirements and deficiency diseases of the constituents of food
- Preparation, Preservation and Storage of Food
- Introduction to Diet Therapy
- Community Nutrition
- Common Preparations and Practicals

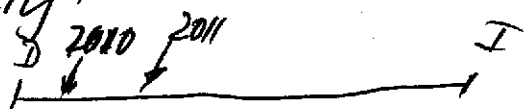
13.33

INCON 2002:

NURSING encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

Definition - Context -

ROPER, LOGAN & TIERNEY (1976): "Nursing is helping a person towards his personal independent pole of the continuum of each activity of daily living (ADL); helping to remain there, helping to cope with any movement towards the dependant pole or poles; in some instances encouraging to move towards the dependant pole or poles because man is finite, helping him to die with dignity"

Poles of mobility  I

ANA: Nursing is the protection, and optimization of health and abilities, prevention of the illness and injury, alleviation of suffering through the diagnosis and treatment of the human response, and the advocacy in the case of individuals, families, communities and populations related to Advocacy -

RCN: The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

Notes:-

In a within definitions — one who is appropriate in the context the definition is used.

CONCLUSION

Nursing is too broad & dynamic a concept to be defined effectively.

Nursing is both an art, and science & technology.

multifaceted: physical, psychological, social,

emotional, environmental, spiritual.

A definition of nursing would be too restrictive for the ~~whole~~ profession which it is.

In practice some specifications are necessary for purposes of curriculum formulation, specialty, service, education and research —

What can a group of nurse do to win the who need nursing
The End
That's all folks

Nursing

Nursing Management &
Educ 1

Page 1

The mission of nursing in society is to help individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work. This requires nurses to develop and perform functions that relate to the promotion and maintenance of health as well as to the prevention of ill health.

Nursing also includes the planning and implementation of care during illness and rehabilitation, and encompasses the physical, mental and social aspects of life as they affect health, illness, disability and dying. Nursing is the provision of care for individuals, families and groups throughout the entire lifespan - from conception to death. Nursing is both an art and a science that requires the understanding and application of the knowledge and skills specific to the discipline. It also draws on knowledge and techniques derived from the humanities and the physical, social, medical and biological sciences.

NURSING AS PROFESSION

Jay Seegolam
April 2014

NURSING AS PROFESSION

At the end of this session, students will be able to:

- ❖ state the criteria for professional practice
- ❖ Compare Nursing to the criteria of a profession
- ❖ Describe the various roles of a professional Nurse

OCCUPATION/VOCATION/PROFESSION

- What is the difference?
- Where do we categorise Nursing?

OCCUPATION

- A person's regular work or profession; job or principal activity

Collins English dictionary

- A type of job that requires special education, training, or skill

Merriam-Webster dictionary

VOCATION

- A strong feeling of suitability for a particular career or occupation: *not all of us have a vocation to be nurses or doctors*
Oxford dictionary
- A job that you do because you feel it is your purpose in life & for which you have special skills
Macmillan Dictionary
- A strong desire to spend your life doing a certain kind of work (such as religious work)
Merriam-Webster dictionary

PROFESSION

Definitions:

- A paid occupation, especially one that requires advanced education and training
Oxford dictionary(1992)
- A calling requiring specialised knowledge & often long and intense academic preparation"
Webster's New Collegiate Dictionary (1980)

CRITERIA OF A PROFESSION

- Unique body of knowledge
- Special education
- Has a regulating body
- A code of ethics regulating practice
- Beneficial for public & practitioner
- Autonomy for practice
- Accountability
- Expertise

PROFESSIONALISM

Definitions:

- "the skill or qualities required or expected of a member of a profession"

Oxford dictionary(1992)

- "Professionalism is often associated with professional behaviour, that is a concept of behavioural practice which can be considered 'professional' regardless of that the fact the occupation may not feature as a professional entity"

Cook, 1992)

CHARACTERISTICS OF NURSING AS A PROFESSION

- Has a systematic body of knowledge
- Work as specialist/expert at advanced level
- Autonomy
- Responsibility & accountability
- Requires advanced education
- Remunerated
- Self-regulation (Nursing Council of Mauritius)
- Has a code of professional conduct
- Professional image (uniform, language, jargons & values specific to Nursing)
- Altruism (service for others)

ROLES OF A PROFESSIONAL NURSE

- Royal College of Nursing (RCN)

1. To promote and maintain health.
2. To care for people when their health is compromised.
3. To assist recovery.
4. To facilitate independence.
5. To meet needs.
6. To improve/maintain well being/quality of life.

ROLES OF A PROFESSIONAL NURSE

- International Council for Nurses (ICN)

1. To promote health
2. To prevent illness
3. To restore health
4. To alleviate suffering

PROFESSIONALISM OF NURSING

Profession	Full time occupation	First training school	First legislation
Medicine	1700	1785	1779
Law	17 th century	1784	1817
Nursing	17 th century	1851	1909

BARRIERS TO NURSING PROFESSIONALISATION

External (extrinsic) factors

- Historical influence of church
- Nursing education level
- Medical dominance

2. Internal (intrinsic) factors

- Female dominance
- Lack of assertiveness

CONCLUSION

- Nursing is well established as a profession
- Unlike other professions, Nursing has struggled a lot to attain the status of a profession
- Nursing has faced barriers to professionalism
- Multiple roles of a professional Nurse
- Nursing also takes a vocational dimension due to its altruistic nature
- Values makes nursing a noble profession

NURS1008:Nursing Management & Education 1

NURSING AS A PROFESSION

(NME)

INTRODUCTION TO THE MODULE

- Has 4 concepts
- 1. Nursing as a profession (Jay)
 - $3 \times 4.5 = 13.5$ Hrs
- 2. Ethico-moral aspect of Nursing (Jay)
 - $3 \times 4.5 = 13.5$ Hrs
- 3. Legal foundations of Nursing (Mrs. Nathoo)
- 4. Professional & Personal development (Mrs. Nathoo)

NURSING AS A PROFESSION CONTENT

1. Definitions of Nursing
2. Criteria of a profession
3. Characteristics of nursing as a profession
4. Levels of proficiency
5. Concept of professional accountability
6. Elements of professional accountability

LEARNING OUTCOMES

- Clarified at the beginning of each session
- At the end of this session, students will be able to:
 - From various definitions of Nursing recite one and justify his/her choice
 - State the criteria for professional practice
 - Compare Nursing to the criteria of a profession
 - Describes the various roles of the professional Nurse

TEACHING METHODS

1. Lecture
2. Group work
3. Questions & Answers
4. Handouts

TEACHING AIDS

- Power point
- White board

CONCEPT

- A concept of a particular subject is the way in which it is viewed.
- As cells are units of the body, so concepts are units of the mind which help us to put thoughts & ideas into some sorts of order which makes sense of the world.
 - Examples: Nursing, health, care, caring, leadership, ...
- Nursing is a very large collection of concepts such as, society, environment & health

VALUE

- Principles or standards of behaviour. One's judgment of what is important in life.
 - Oxford Dictionary*
- Important & lasting beliefs or ideals about what is good or bad & desirable or undesirable
- Values have major influence on a person's behaviour & attitude & serve as a broad guideline in all situations.

UNDERSTANDING NURSING

- History of Nursing
- What Nursing means to you?
- How would you define Nursing?
- Explore some definitions of Nursing
- Critically select one definition of Nursing

HISTORY OF NURSING

- Ancient Rome: BC
 - Soldiers were trained to care for injured companions
 - Temple hospitals & Roman noblewomen were Nurses
- Europe (1095-1271): Crusades (religious wars)
 - 1st hospital in Jerusalem
 - 1st Nurses: the knights of St. John (men)
- Late middle age:
 - Men returning from war wanted to take over social dominance with help of church
 - Political mechanism to devalue & deskill women with healing skills

HISTORY OF NURSING

- Catholic church (16th – 19th centuries):
 - Advocated that the art & science of caring was a vocation – a calling from God
 - Nuns as Nurses
 - Reform in Nursing based on scientific observations started in France & Germany (stethoscope & thermometers were designed)
- England:
 - Elizabeth Fry (1780-1845): Institute of Nursing
 - Florence Nightingale (1820-1910): Scutari in Turkey, 'the lady with the lamp', mother of modern Nursing

EXPLORING DEFINITIONS OF NURSING

- Lay Definitions
- Professional Definitions

LAY DEFINITIONS OF NURSING

1. Suckling an infant
2. A female servant who takes care of young children
3. A person who takes care of the sick or wounded
4. Doctor's assistant
5. Follows medical instructions

DEFINITIONS OF NURSING

- OREM (1985) "Nursing is deliberate action to bring about humanely desirable conditions in persons and their environment"
- VIRGINIA HANDERSON (1961) "The unique function of nurses is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him regain independence as soon as possible"

DEFINITIONS OF NURSING

- ROPER, LOGAN & TIERNEY (1976): "Nursing is helping a person towards his personal independent pole of the continuum of each Activity of Daily Living (ADL); helping to remain there, helping to cope with any movement towards the dependant pole or poles; in some instances encouraging to move towards the dependent pole or poles because man is finite, helping him to die with dignity"

THE 12 ADL

1. Maintaining a safe environment
2. Communicating
3. Breathing
4. Eating & drinking
5. Eliminating
6. Personal cleansing & dressing
7. Controlling body temperature
8. Mobilising
9. Working & playing
10. Expressing sexuality
11. Sleeping
12. Dying

DEFINITION OF NURSING

American Nursing Association (ANA)

- The definition of Nursing per the ANA is Nursing is the protection, and optimization of health and abilities, prevention of the illness and injury, alleviation of suffering through the diagnosis and treatment of the human response, and the advocacy in the care of individuals, families, communities and populations.

DEFINITION OF NURSING

Royal College of Nursing (RCN) (1987)

The use of clinical judgment in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

INTERNATIONAL COUNCIL OF NURSES (2002)

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

WORLD HEALTH ORGANIZATION (2000)

The mission of nursing in society is to help individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work. This requires nurses to develop and perform functions that relate to the promotion and maintenance of health as well as to the prevention of ill health. Nursing also includes the planning and implementation of care during illness and rehabilitation, and encompasses the physical, mental and social aspects of life as they affect health, illness, disability and dying. Nursing is the provision of care for individuals, families and groups throughout the entire life-span – from conception to death. Nursing is both an art and a science that requires the understanding and application of the knowledge and skills specific to the discipline. It also draws on knowledge and techniques derived from the humanities and the physical, social, medical and biological sciences.

CONCLUSION

1. Nursing is too broad & dynamic a concept to be defined effectively
2. Nursing is both an art & science
3. Multi-factorial: physical, psychological, social, emotional, environmental, spiritual
4. "a definition of nursing would be too restrictive for the profession." UKCC, 1999
5. In practice some specifications are necessary for purposes of such as policy formulation, specifying services, education & research

NURSING AS PROFESSION

At the end of this session, students will be able to:

- ❖ state the criteria for professional practice
- ❖ Compare Nursing to the criteria of a profession
- ❖ Describe the various roles of a professional Nurse

OCCUPATION/VOCATION/PROFESSION

- What is the difference?
- Where do we categorise Nursing?

OCCUPATION

- A person's regular work or profession; job or principal activity

Collins English dictionary

- A type of job that requires special education, training, or skill

Merriam-Webster dictionary

VOCATION

- A **strong feeling of suitability** for a particular career or occupation: *not all of us have a vocation to be nurses or doctors*
Oxford dictionary
- A job that you do because you feel it is your **purpose in life** & for which you have special skills
Macmillan Dictionary
- A strong desire to **spend your life** doing a certain kind of work (such as religious work)
Merriam-Webster dictionary

PROFESSION

Definitions:

- A paid occupation, especially one that requires advanced education and training
Oxford dictionary(1992)
- A calling requiring specialised knowledge & often long and intense academic preparation
Webster's New Collegiate Dictionary (1980)

CRITERIA OF A PROFESSION

- Unique body of knowledge
- Special education
- Has a regulating body
- A code of ethics regulating practice
- Beneficial for public & practitioner
- Autonomy for practice
- Accountability
- Expertise

PROFESSIONALISM

Definitions:

- "the skill or qualities required or expected of a member of a profession"
Oxford dictionary(1992)
- "Professionalism is often associated with professional behaviour, that is a concept of behavioural practice which can be considered 'professional' regardless of that the fact the occupation may not feature as a professional entity"
Cook, 1992)

CHARACTERISTICS OF NURSING AS A PROFESSION

- Has a systematic body of knowledge
- Work as specialist/expert at advanced level
- Autonomy
- Responsibility & accountability
- Requires advanced education
- Remunerated
- Self-regulation (Nursing Council of Mauritius)
- Has a code of professional conduct
- Professional image (uniform, language, jargons & values specific to Nursing)
- Altruism (service for others)

ROLES OF A PROFESSIONAL NURSE

- **Royal College of Nursing (RCN)**
 1. To promote and maintain health.
 2. To care for people when their health is compromised.
 3. To assist recovery.
 4. To facilitate independence.
 5. To meet needs.
 6. To improve/maintain well being/quality of life.

NURS

PROFESSIONAL ACCOUNTABILITY

JaySeeg.

2304

How you heard about accountability?

2014

Professional nurses needs to become accountable.

D.

A student is accountable for his own learning -

1500

& do some reading about accountability

* At ^{LO} the end of the session, the student will be

able to:

- > Discuss the concept

- > Describe the basic rights & responsibilities of a

professional nurse.

* Reflect on the standard

Definition:

1. The ability and willingness to assume responsibility for one's actions and accepting the consequences of one's behaviour? (Fundamentals of Nursing; Concepts, Process and Practice: Kozier, Erb, Blais Wilkinson, Addison Wesley, 5th Ed. PL410.

2.

3.

4. The responsibility and answerability of one's actions or omissions, omissions.

we are accountable for our decision & indecision -

Semester 1

⑦

XKWR1

NURS

JAYBERG.

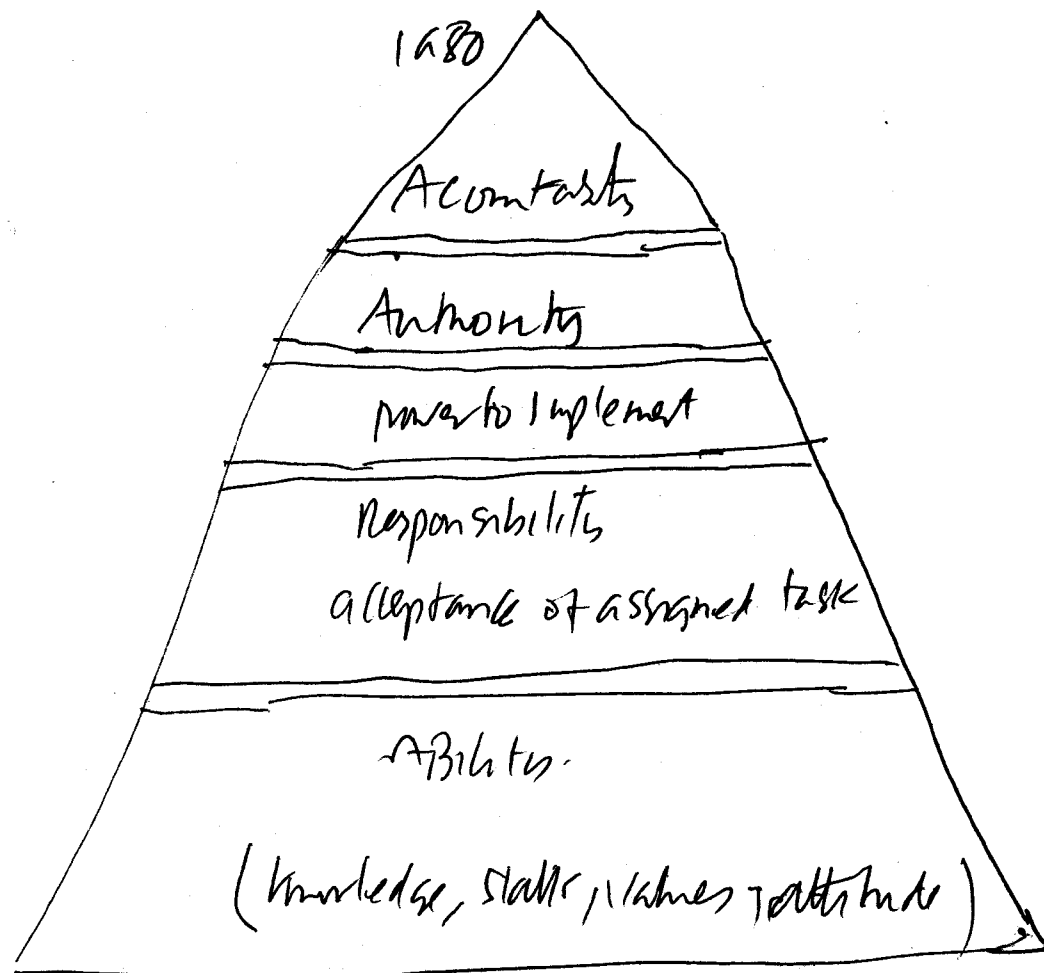
2304

2014

Pre conditions for Accountability

REBECCA BERGMAN

1980



1518

⚠ Push, social, External, extrinsic factors or societal factors

1: The rising cost of health.

2: Competition.

⚠ Internal (intrinsic) or "pull" professional factors.

1: Professional requirement -

2: Higher education in nursing -

3: Life long learning culture:

PS 26.

This week meeting with Castellon on a group -

320 public 11 -

8

Semester 1

YEAR 4

2304
2014
1310

Levels of Proficiency

from novice to expert

An American nurse did research on how

learners nurse work.

LEARNING OUTCOME

At the end of the session, students will be able to:

Share
work &
Study

△ Illustrate Benner's levels of proficiency -

- All Nurses are not competent.
- Some nurses are not competent at all.
- All competent nurses are not equally competent
- Some nurses are more competent than others
- Few nurses are very very competent.
- Very few nurses are very competent: experts!
- What are the different levels of competency?
- What is needed to climb the competency ladder?

Patricia Benner (1984)

- Studied & described the stages of skill acquisition in

Nursing

- Skill acquisition is SEQUENTIAL: from the stage of novice
- 5 stages of skill acquisition.

13:18

Semester

①

XEP2

Numb 1001

LEVELS of Proficiency

Jamdeep

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2014

5

5 stages

1. NOVICE

2. ADVANCED BEGINNER

3. COMPETENCY.

4. PROFICIENCY

5. EXPERTISE

- NOVICE = beginner.

- has no experience in the situation in which they

are expected to perform

- The novice lacks confidence to demonstrate skills.

practice and requires continued verbal and physical cues.

- Practice is within a prolonged time period and he/she

is unable to use discretionary judgment

- There are no rules must be given rules to follow.

Advanced Beginner.

- Marking needed

Semester 1

②

Year 1

1hrs/001

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2014

* Advanced begins demonstrate marginal

acceptable performance because he understands an & prior

experiences comparable in actual situations.

+ Knowledge is developing.

* He/she is skilful in parts of the practice area.
Requiring occasional supervision and guidance.

* Has some basic knowledge about the job

* Cannot perform his/her own

Competent Practitioner.

* Competence is demonstrated by the nurse who has been

in the job with similar situation for two or three years

* Nurse plan & perform patient's care after much
analysis of patient problems.

* Has authority but authority compromised due to
lack of own experience

* Nurse is confident & can perform independently

* Having the knowledge & experience to

Proficient Practitioner

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2014
* Perceives Situation as a whole (holistically)
rather than parts

* Has high expertise of self guidance in
difficultly practical situation.

* Uses Reflexive Skills — * Reflection on Action ^{mapar / action}
Reflection in action (to reflect
on past action during a
similar action)

* Independent / autonomous & confident.

* state of excellent Excellence.

Reflection on Action.
EXPERT PRACTITIONER

° Expertise is the perceived highest state of skill
acquired in a particular field by someone.

* Expert operate from a deep understanding of
the total situation by taking a holistic view. Sees the
big picture

* Intuitive

* Intuition is having the ability to make the right decision
at the right time without having recourse to any rational
(reasoned) analysis in a sequential way - (anecdotal)

PATRICIA BENNER'S LEVELS OF PROFICIENCY

FROM NOVICE TO EXPERT

Jay

LEARNING OUTCOME

At the end of the session, students will be able to:

- Illustrate Benner's levels of proficiency

COMPETENCY LEVELS

- All Nurses are not competent
- Some Nurses are not competent at all
- All competent nurses are not equally competent
- Some Nurses are more competent than others
- Few Nurses are very competent
- Very few Nurses are very competent: experts!
- What are the different levels of competency?
- What is needed to climb the competency ladder?

PATRICIA BENNER (1984)

- Studied & described the stages of skill acquisitions in Nursing
- Skill acquisition is sequential: from one stage to another
- 5 stages of skill acquisition

STAGES OF SKILL ACQUISITION

1. Novice
2. Advanced Beginner
3. Competency
4. Proficiency
5. Expertise

NOVICE

- Novice = beginner
- has no experience in the situations in which they are expected to perform
- The Novice lacks confidence to demonstrate safe practice and requires continual verbal and physical cues.
- Practice is within a prolonged time period and he/she is unable to use discretionary judgement.
- Therefore, novices must be given rules for behaviour to guide their performance

ADVANCED BEGINNER

- Advanced Beginners demonstrate marginally acceptable performance because the nurse has had prior experience in actual situations.
- Knowledge is developing.
- He/she is skilful in parts of the practice area, requiring occasional supervision & guidance.
- Has some basic knowledge about the procedure & situation
- Cannot practice on his/her own
- Mentors are needed

COMPETENT PRACTITIONER

- Dictionary definition: "Having the qualifications required by law."
- Nurse is confident & can practice independently.
- Has authority but autonomy compromised due to lack of rich experience.
- Nurse plans patient care after much analysis of patient problems
- Competence is demonstrated by the nurse who has been on the job in the same or similar situations for two or three years.

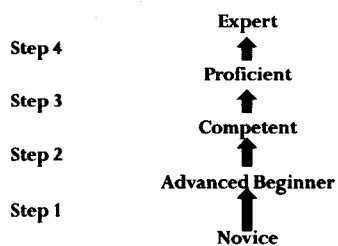
PROFICIENT PRATITIONER

- Perceives situation as a whole (holistically) rather than parts.
- Has rich experience for self-guidance in difficult practical situations.
- Uses reflective skills
 - Reflection on action (to reflect on a past action)
 - Reflection in action (to reflect on a past action during a similar action)
- Independent/autonomous & confident.
- State of excellence.

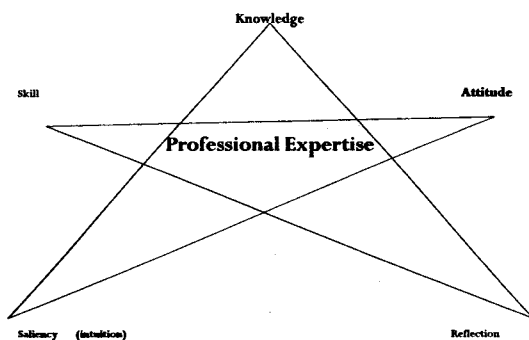
EXPERT PRACTITIONER

- Expertise is the perceived highest state of skill acquisition in a particular field by someone.
- Experts operate from a deep understanding of the total situation by taking a holistic view. Sees the big picture
- Intuitive
- Intuition is having the ability to make the right decision at the right time without having recourse to any rational (reasoned) analysis in a sequential way

THE 5 STAGES



A CONCEPTUAL FRAMEWORK FOR EXPERTISE (RCN)



CONCLUSION

- Benner described 5 stages of skill acquisition
- Nurses need to know these stages to assess & measure progress of self & others
- We need the following to move from novice to expert:
 - Knowledge
 - Skill
 - Attitude
 - Reflexivity
 - Wisdom
 - Time
 - Intuition

REFLECTION

- To reach expertise is a vision.
- Learning to move towards Expertise is a mission.
- To stabilise at Expertise level is an illusion.

*Because
"there is always more we'll never know
than we'll ever know"*

NURS

A conceptual framework for Expertise.

Jayseeg

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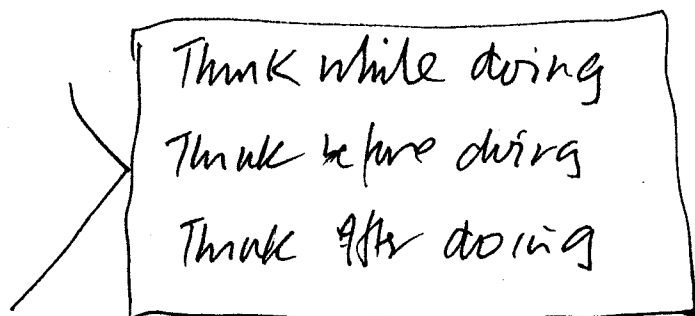
2014

1440

3

- △ we don't need hard workers.
- △ we need smart workers

Methodology



3T

How to improve practice? work on it on

Schon

2 increments - work on Action - in action -

To reach expertise is a vision

Learning to move towards Expertise is a mission

To stabilise at Expertise level is an illusion

Because.

"There is always more w/ll ever know than what

ever know"

Semester 1

(6)

Year 1

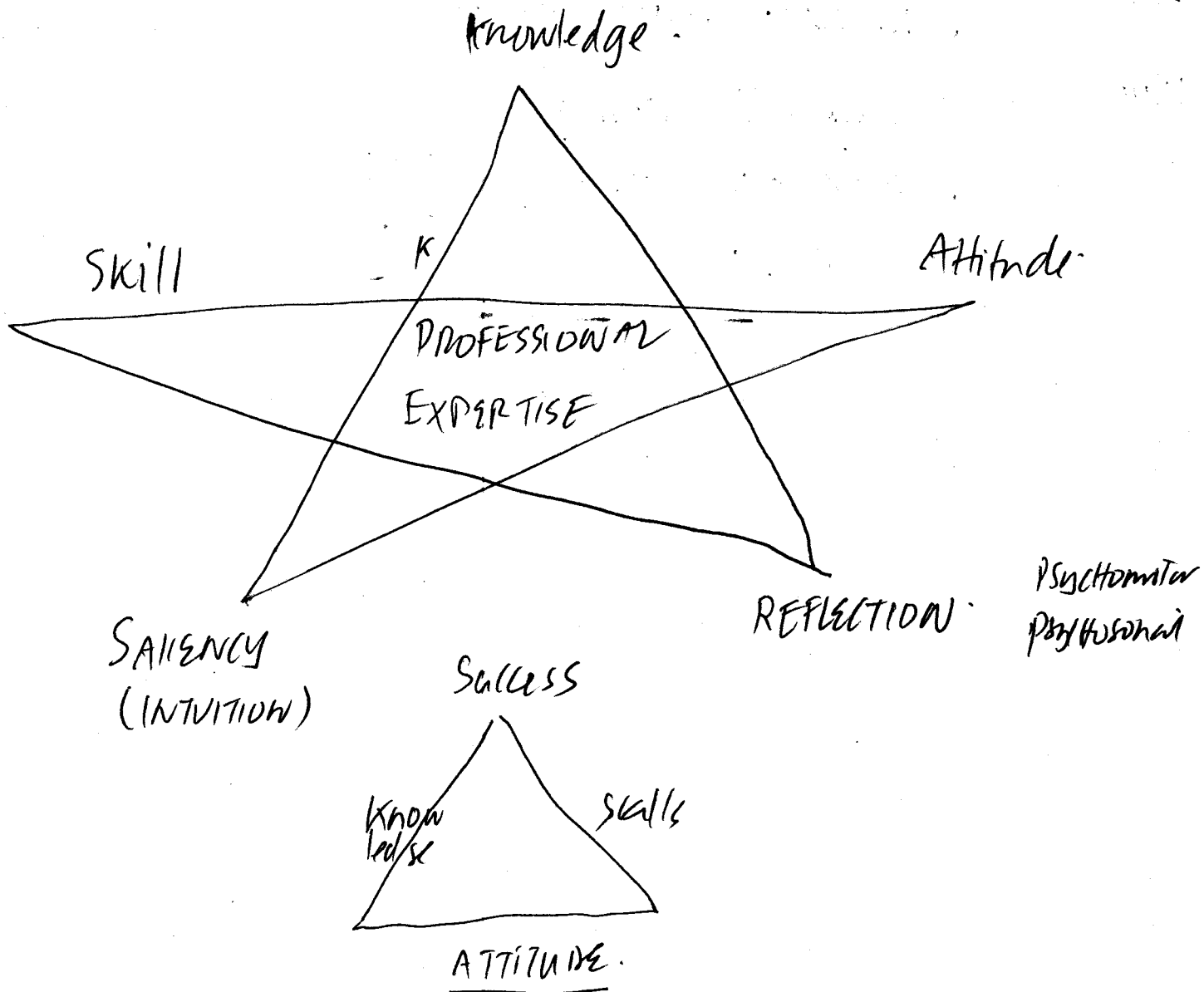
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A conceptual framework for EXPERTISE (RCN)

2014

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— CONCLUSION —

* Benner described 5 stages of skill acquisition

* Nurses need to know these stages to assess & measure

progress & self-reflection

* We need the following to move from novice to expert:

□ Knowledge □ Skill □ Attitude □ Reflexivity □ Wisdom
□ TIME □ Intuition □

Nurs 1000

hw BRYA

02-05

hw 10 Surg

1. Inflammation

2.

Tissues H

A: Fungus 5

R: Bacteria 5

C: Virus 5

D: Parasite 5

Theodan - Uniform Resolutions -

NURS 1002

hw 624A

02-05-

hivis Surgg

1. inflammation

2.

Tissues H

A: fungus 5

R: bacteria 5

C: virus 5

D: parasite 5

Theodan - uniform neocent -

MAE

Upashna: Mob: 58250297

Ismail mob: 57985252

Kashwan 59290211.

Lisa mob: 57240804

1: Hospital Quets

2: Spill in Hospital -

- Vascular 2
 Transport 1
 Transport -
 Respir 2
 Organelles - 3 ~~A~~
 Cellschise - 4

ORGANELLE ^{more than one}
 # Part Cells
 Organelles
 1 Nucleus
 2 Mitochondria
 3 Ribosomes
 4 Golgi apparatus
 5 Endoplasmic Reticulum
 6 Lysosomes
 7 Cytoskeleton
 8 Spindle
 9 Potar
 10 Microtubule
 11 Centrosome
 12 Cells
 13 Intestine

Skeletal muscle Cells $\leftarrow$ 2 nuclei

A: nucleus - genetic material

B: egg production - aerobic respiration $\leftarrow$ O₂

C: Synthesize protein from amino acids Ribosome RIBOSOMES -
 Synthesis

D: Golgi apparatus - Endoplasmic Reticulum make granules from
 Golgi body. PACKING

E: Rough Ruffled Smooth - System lymph, hormones SYNTHESIS
 Protein

F: Lysosomes - waste from Golgi apparatus - break down
 enzymes
 G: Mitochondria - $\leftarrow$ ~~A~~

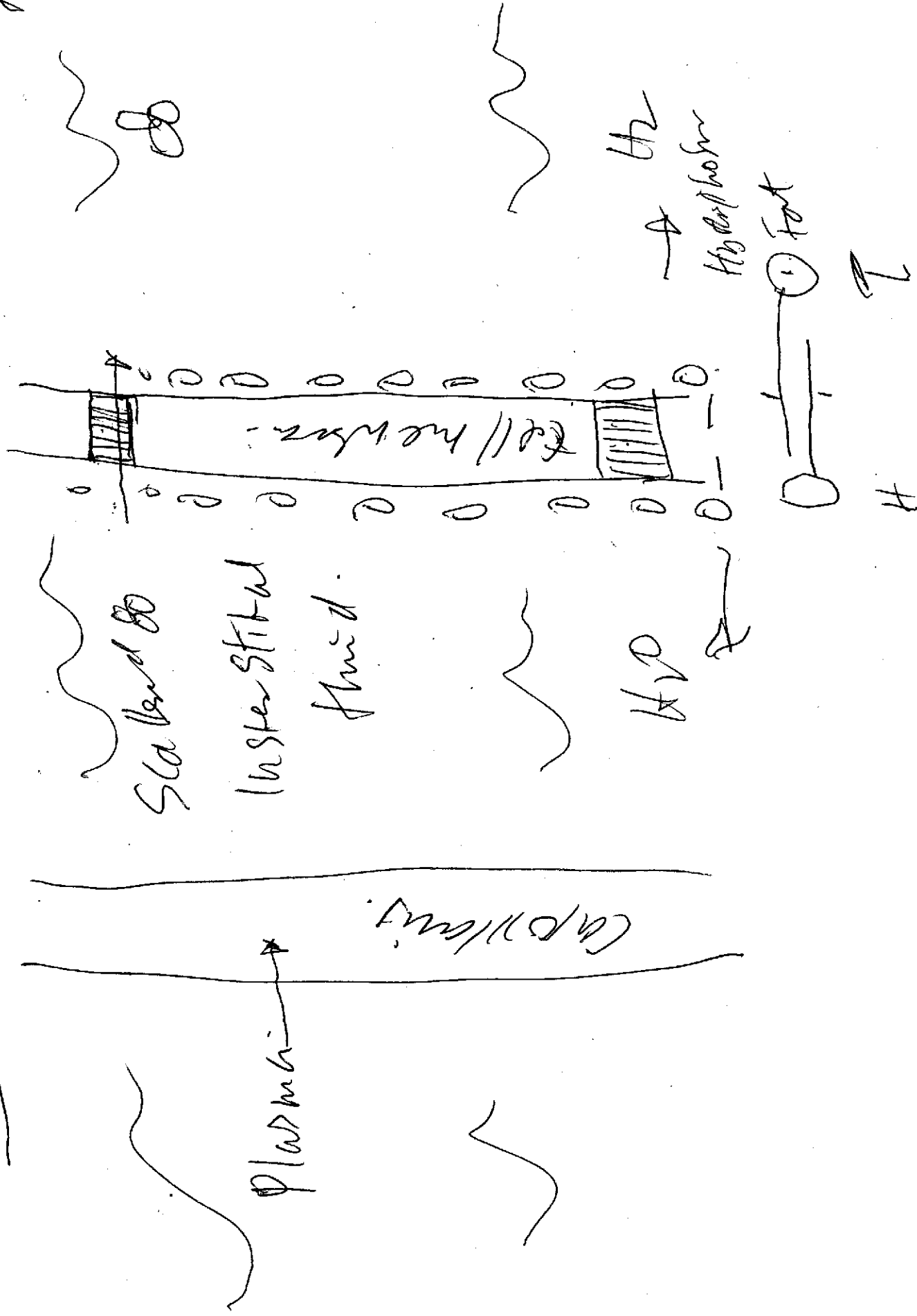
H: Cytoskeleton provide support - Structure

Extracellular matrix

Plasma

Intracellular

fluid



Passive Transport



Diffusion Osmosis

Active Transport

①
Molecular Transport



Trans + EXO

↳
ATP -
against
concentration
gradient

Solute - Facilitated
transport

Proteins

Amoeba
Sugar - Soluble
/ Cells

Concentration
100 - Concentration
hypo - low concentration
hyper - high concentration

Cell division

① ^{Prophase} Mitosis — is procs. separates chromosomes & 15 ab

in the info has IDENTICAL sets. 1st followed by Nucleus

division — prophase — metaphase — anaphase — Telophase

② meiosis — . Telophase — first division —
Second division

XY — XX.

③

ETHICO-MORAL ASPECT OF NURSING



LEARNING OUTCOMES

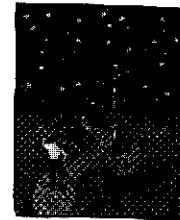
At the end of the session, students will be able to:

- Reflect in small group on the concept of ethics
- Compare legal & ethical concepts
- Differentiate the theories of teleology & deontology
- Describe the major ethical principles that affect health care; identify examples that relate to each
- Analyse situational applications of the provisions of the Code of Ethics for Nurses
- Utilise ethico-moral principles as guide in resolving problems in Nursing practice
- Use the framework for ethical decision-making in resolving an ethical dilemma

INTRODUCTION

- Nurses make decisions & take actions all the time
- Some decisions & actions are simple & straightforward
 - Examples: Patient asks for a painkiller, Nurse administers the prescribed medication
- Some decisions can be influenced by:
 - Patients' personal & cultural values
 - Nurses' personal values & professional values/responsibilities
 - Example: Terminally ill patient wants to smoke
- When values conflict, decision making becomes complex & difficult as there is no obvious clear cut course of action. This is called moral dilemma.
- Choose decision between two equally desirable or undesirable alternatives
- Examples of moral dilemma:
 - A 90 year old terminally ill patient with lung cancer wants to smoke on his hospital bed.
- Ethics, which is a branch of philosophy, helps to understand & sort out moral dilemmas

MORAL DILEMMA



GLOSSARY

- **BELIEF:** a feeling that something is good, right or valuable
- **VALUE:** one's judgement of what is important in life
- **CULTURE:** characteristics of a particular group, e.g., language, religion, social habits, music, food, beliefs, values, traditions, way of thinking
- **PRINCIPLE:** a rule or standard, especially of good behaviour, that act as a guide
- **PHILOSOPHY:** study of ideas about knowledge, truth, nature & meaning of life, etc. (Ethics is 1 of the 5 branches)

ETHICS

- It is the study not only of how our thoughts are good or right, but also how our actions and their consequences are good or right.
- Judgment about Good v/s Right
- Every thought or action can be valued in terms of whether it possesses good or bad values.
- Ethics is reserved for values which are exclusively good or right.
- In Nursing, ethics is not just about thinking, it is also about doing because it is a practical profession.

CATEGORIES OF VALUES

- **Moral values:** honesty, respect, integrity, compassion
- **Non-moral values:** cleanliness, organisation, dress codes, grooming, quality

TYPES OF VALUES

- **Personal values:** excellence, cleanliness, honesty
- **Cultural values:** tradition, family, exercise, meditation
- **Religious values:** non-violence, respect of life
- **Professional values:** dress codes, hierarchy, fairness, care, compassion, promotion, status
- **Corporate values:** Quality, integrity, respect, compassion, unity, commitment
- **Human/Spiritual values:** respect, love, non-violence, tolerance

MORALITY

- The terms Ethics & morality are often used to mean the same thing
- Morality is a system of ideas of right & wrong
- Morality is ones own beliefs about what is right and what is wrong behaviour

MORALS & ETHICS

	MORALS	ETHICS
WHAT IS IT?	Defines our own beliefs about what is right and what is wrong behaviour	Defines not only how our thoughts are good or right, but also how our actions and their consequences are good or right
WHERE DOES IT COME FROM?	Internal (Individual)	External (society, profession)
WHY WE DO IT?	Own beliefs & values	Social rules
WHAT IF WE DON'T DO IT?	May feel uncomfortable, remorse, depressed	May face: disapproval, disciplinary action at work, legal action (civil law)

LEGAL V/S ETHICAL CONCEPT

- Is Nursing totally autonomous or totally self-regulating?
- Nursing as any profession, and its individual members are, like any other citizens, are subject to the laws of the land.
- Many Nursing actions may be both legal & ethical. E.g., termination of a life threatening pregnancy
- Some Nursing actions may only be legal not ethical. E.g., abortion in case of rape even if the law supports but it is against the religious beliefs & values of the Nurse
- Some Nursing actions may viewed as being only ethical not legal. E.g., termination of life threatening pregnancy without a legal support
- Ethics & the law can be confusing because an individual may have both legal rights & moral rights
- Legal right: claims recognised as valid by the legal system.
- Moral right: derived from customs, traditions & ideas that are not upheld by the law.
- Example: a patient at the end-stage of a serious illness may claim a moral right to die & not to be kept on ventilator & intravenous nutrition if he/she goes into irreversible coma. Yet disconnecting the patient from the ventilator is illegal in some countries.

EXAMPLES OF LAWS

- Criminal law: deliberate injury to a patient
- Employment law: Employment Right Act (2008)
- Civil law: injury to patient through negligence
- Public laws: mental health act, child abuse, substance abuse, ...

ETHICS IN HEALTHCARE

- Healthcare involves decisions & choices that affect other people which require judgment to be made about whether particular course of action is right or wrong.
- Example: wounded soldier undergoing amputation to avoid septicaemia & death
- Ethical theories: Deontology & consequentialism

ETHICAL THEORIES

Most ethical theories fall in 2 types:

1. Deontology
2. Consequentialism or Teleology or Utilitarian

DEONTOLOGY

- Deontology comes from the Greek word "deontos" meaning duty
- Deontologists believe that we have a duty to act according to certain universal rules, for example:
 - The biblical "do to others what you want others to do to you"
 - Respect all people
 - Duty to care
 - Do good
 - Duty to be truthful in all declarations

Deontological theories make decision making apparently easy because, as long as we obey the rules, then we must be doing the right thing, regardless of the consequence.

DEONTOLOGY cont.

1. Deontological: We have a duty to act in accordance with certain universal rules, e.g., "Do unto others as you would they do unto you", duty to respect, duty care, duty to do no harm
 - Deontology makes decision making easy
Obey rules = doing right things (regardless of consequence)
2. Consequentialism concerned with end results not the means

CONSEQUENTIALISM

- Is concerned with the consequence or end result not only the means
- According to this principle, a person should always act in such a way that will produce more good or benefit than disadvantages
- It aims for the greatest good or pleasure for the greatest number of people. The interests of the majority always take precedence over those of the individual. Example:
 - Smoking is prohibited in public areas because the health of the public is more important than the right of the individual to smoke

ETHICAL PRINCIPLES

- A principle is a set of rules, standards, beliefs or ideas that act as a guide
- Ethical principles can help to clarify the decisions that have to be taken at work.

6 Ethical Principles

1. Autonomy
2. Non-maleficence
3. Beneficence
4. Justice
5. Veracity
6. Fidelity

AUTONOMY

- Ethical principle that obliges one to allow individuals to self-determine their own plans & actions.
- It entails respecting the personal liberty of individuals & the choices they make, based on their own personal values & beliefs given that they have been provided with all necessary information & knowledge.
- It refers to a person's capacity to choose freely for themselves & be able to direct their own life
- Not everyone has autonomy
 - People with learning difficulty
 - Mental illness
 - Young children
 - Older people with mental confusion

NON-MALEFICENCE

- Requirement that health care providers "do no harm" to their client's - intentionally or unintentionally
- Obligation to avoid harm
 - Example: provision of sterile needles & syringes and condoms to drug addicts
- Risk assessment for potential harm, for example:
 - Side effects of a medication
 - Pain related to a procedure
 - Possible complications of surgery
 - Anxiety & stress related to procedures
- Nurses decisions must not produce harm to patients

BENEFICENCE

- Doing or promoting good as well as preventing, removing & avoiding evil or harm
- The obligation to do good
- Nurse must inform the patient that the aim of any action taken is for his/her benefit

JUSTICE

- Justice requires that people are treated equally
- Just & fair distribution of health care resources
- Fairly = equally or reasonably
- Nurse must decide what is just & fair distribution
- Should resources be distributed equally or according to need?
- Equality = equal amount/share irrespective of need
- Equity = according to needs (not equal amount)
- How a Nurse allocates his/her time to patients?

VERACITY

- The obligation to tell the truth & not to lie
- Patients have the right to know the truth about their health. Example: When vital signs are not normal
- Truthfulness commands respect & builds a good Nurse-patient relationship
- A Nurse is reliable if he/she is trustworthy
- Not telling the truth is not the same as lying. Example a Nurse can withhold an information when not asked
- Veracity can be bitter, therefore must be handled with care & tact. Example: Young patient diagnosed with cancer

FIDELITY

- Obligation to remain faithful to one's commitments towards self, clients, colleagues & organisation
- Commitments such as keeping promises & maintaining confidentiality
- Exceptions to both obligations can sometimes be made if the end result will produce more good than if the promise & confidence are not broken
- Examples:
 - A patient confesses to you that she is going to commit suicide
 - A child confesses that he/she is being sexually abused
- In both cases the Nurse has an obligation to prevent harm i.e., Non-Maleficence

CODE OF ETHICS

- written list of a profession's values & standards of conduct
- framework for decision making
- general statements
- offer guidance
- periodically revised
- not legally enforceable as laws but consistent violations indicate an unwillingness by the person to act in a professional manner & license can be suspended or revoked

CODE OF ETHICS

- Definition: A formal statement by a group that establishes and prescribes moral non-moral standards of behaviours for members of the group
- The code of ethics for Nurses in Mauritius
- The International Council of Nurses (ICN) code of ethics for Nurses
- The Nightingale Pledge

THE CODE OF ETHICS OF NURSES IN MAURITIUS

- Please see copy

THE ICN CODE OF ETHICS

- Please see copy

THE NIGHTINGALE PLEDGE composed by Lystra Gretter

- I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician, in his work, and devote myself to the welfare of those committed to my care.

ETHICAL DECISION MAKING

- Nurses being professionals have the responsibility & are accountable for making decisions that are ethical so as to protect the client, public, the hospital, the profession & themselves
- Ethical decision making is an inexact process
- There is no secure & definite action
- To make ethical decisions, a tool (framework) is helpful

ETHICAL DECISION MAKING FRAMEWORK (Andrew Jameton, 1984)

- | | |
|-------------------------|--------------------------------------|
| 1. IDENTIFY THE PROBLEM | 4. THINK THE ETHICAL PROBLEM THROUGH |
| 2. GATHER DATA | 5. MAKE A DECISION |
| 3. IDENTIFY OPTIONS | 6. ACT & ASSESS |

IDENTIFY THE PROBLEM

- State the problem clearly
- Is there any ethical issue?
- Do 2 or more values or principles appear to be in conflict?

GATHER DATA

- What is the history?
- Who are the main people involved?
- What are their views & interests?
- What is the patient's situation?
- Any legal implications?

IDENTIFY OPTIONS

- What are the possible courses of action?
- What are the probable impact of each course of action?
- What future decisions are likely to come up for each option?

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WHAT IS IT?	Defines our own beliefs about what is right and what is wrong behaviour	Defines not only how our thoughts are good or right, but also how our actions and their consequences are good or right
WHERE DOES IT COME FROM?	Internal (Individual)	External (society, profession)
WHY WE DO IT?	Own beliefs & values	Social rules
WHAT IF WE DON'T DO IT?	May feel: uncomfortable, remorse, depressed	May face: disapproval, disciplinary action at work, legal action (civil law)

LEGAL V/S ETHICAL CONCEPT

- Is Nursing totally autonomous or totally self-regulating?
- Nursing as any profession, and its individual members are, like any other citizens, are subject to the laws of the land.
- Many Nursing actions may be both legal & ethical. E.g., termination of a life threatening pregnancy
- Some Nursing actions may only be legal not ethical. E.g., abortion in case of rape even if the law supports but it is against the religious beliefs & values of the Nurse
- Some Nursing actions may viewed as being only ethical not legal. E.g., termination of life threatening pregnancy without a legal support
- Ethics & the law can be confusing because an individual may have both legal rights & moral rights
- Legal right: claims recognised as valid by the legal system.
- Moral right: derived from customs, traditions & ideas that are not upheld by the law.
- Example: a patient at the end-stage of a serious illness may claim a moral right to die & not to be kept on ventilator & intravenous nutrition if he/she goes into irreversible coma. Yet disconnecting the patient from the ventilator is illegal in some countries.

EXAMPLES OF LAWS

- Criminal law: deliberate injury to a patient
- Employment law: Employment Right Act (2008)
- Civil law: injury to patient through negligence
- Public laws: mental health act, child abuse, substance abuse, ...

ETHICS IN HEALTHCARE

- Healthcare involves decisions & choices that affect other people which require judgment to be made about whether particular course of action is right or wrong.
- Example: wounded soldier undergoing amputation to avoid septicaemia & death
- Ethical theories: Deontology & consequentialism

ETHICAL THEORIES

Most ethical theories fall in 2 types:

1. Deontology
2. Consequentialism or Teleology or Utilitarian

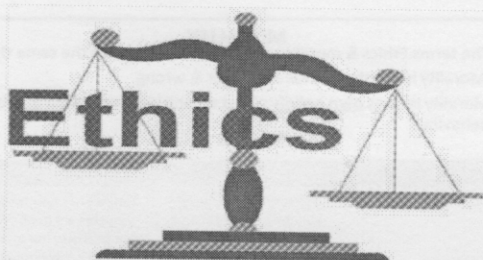
DEONTOLOGY

- Deontology comes from the Greek word "deontos" meaning duty
- Deontologists believe that we have a duty to act according to certain universal rules, for example:
 - The biblical "do to others what you want others to do to you"
 - Respect all people
 - Duty to care
 - Do good
 - Duty to be truthful in all declarations
- Deontological theories make decision making apparently easy because, as long as we obey the rules, then we must be doing the right thing, regardless of the consequence.

DEONTOLOGY cont.

1. Deontological: We have a duty to act in accordance with certain universal rules, e.g., "Do unto others as you would they do unto you", duty to respect, duty care, duty to do no harm
 - Deontology makes decision making easy
Obey rules = doing right things (regardless of consequence)
2. Consequentialism concerned with end results not the means

ETHICO-MORAL ASPECT OF NURSING



LEARNING OUTCOMES

At the end of the session, students will be able to:

- Reflect in small group on the concept of ethics
- Compare legal & ethical concepts
- Differentiate the theories of teleology & deontology
- Describe the major ethical principles that affect health care; identify examples that relate to each
- Analyse situational applications of the provisions of the Code of Ethics for Nurses
- Utilise ethico-moral principles as guide in resolving problems in Nursing practice
- Use the framework for ethical decision-making in resolving an ethical dilemma

INTRODUCTION

- Nurses make decisions & take actions all the time
- Some decisions & actions are simple & straightforward
 - Examples: Patient asks for a painkiller, Nurse administers the prescribed medication
- Some decisions can be influenced by:
 - Patients' personal & cultural values
 - Nurses' personal values & professional values/responsibilities
 - Example: Terminally ill patient wants to smoke
- When values conflict, decision making becomes complex & difficult as there is no obvious clear cut course of action. This is called moral dilemma.
- Choose decision between two equally desirable or undesirable alternatives
- Examples of moral dilemma:
 - A 90 year old terminally ill patient with lung cancer wants to smoke on his hospital bed.
- Ethics, which is a branch of philosophy, helps to understand & sort out moral dilemmas

MORAL DILEMMA



GLOSSARY

- **BELIEF:** a feeling that something is good, right or valuable
- **VALUE:** one's judgement of what is important in life
- **CULTURE:** characteristics of a particular group, e.g., language, religion, social habits, music, food, beliefs, values, traditions, way of thinking
- **PRINCIPLE:** a rule or standard, especially of good behaviour, that act as a guide
- **PHILOSOPHY:** study of ideas about knowledge, truth, nature & meaning of life, etc. (Ethics is 1 of the 5 branches)

ETHICS

- It is the study not only of how our thoughts are good or right, but also how our actions and their consequences are good or right.
- Judgment about Good v/s Right
- Every thought or action can be valued in terms of whether it possesses good or bad values.
- Ethics is reserved for values which are exclusively good or right.
- In Nursing, ethics is not just about thinking, it is also about doing because it is a practical profession.

THINK THE ETHICAL PROBLEM THROUGH

- What principles are involved?

- Patient's right
- Patient's beliefs & values
- Patient's wish
- Professional code of ethics
- Business code of ethics
- Ethical principles: Autonomy, Non-maleficence, beneficence, Justice, Veracity & Fidelity

MAKE A DECISION

- After carefully considering controversial issues, choose a course of action based that best reflects your judgement
- Discuss with other health care staff & your manager
- Present your course of action as "our choice"

ACT & ASSESS

- Carry out the chosen that may be full of surprises
- Compare the actual outcome with your expectation
- Consider how you can improve the decision process next time

GOAL OF NURSE IN ETHICAL DECISION MAKING

- The goal of the professional Nurse is to help the parties involved to respect each other's values and to help individuals prioritise their values and preserve the most important ones in the process of decision making. (Fry, 1989)

APPLICATION ETHICAL DECISION MAKING FRAMEWORK

- Euthanasia
- Refusal of treatment

EUTHANASIA

- Euthanasia is the act of actively or passively killing a person painlessly for reason of mercy (Fry, 1994)
- Two types of euthanasia:
 1. Active euthanasia is the direct killing or ending of someone's life by any method such as lethal injection or a lethal dose of medication.
 2. Passive euthanasia is the withholding or withdrawing of a life-sustaining measure in order to allow a person to die.

CASE EXMPLE: EUTHANASIA

- An elderly patient with terminal cancer expresses his wish to die as he can no more bear the long standing agonising pain. His family members don't want him to suffer any more. The doctor is faced with his duty to preserve life & at the same time to alleviate suffering. He discusses the issue with the Nurse who has 2 options in mind:
 1. To go with the professional code of ethics & continue manage the pain & support life
 2. To respect the wish of the patient by
 - a) Increasing the dose of the pain killer which will finally lead to peaceful death
 - b) To stop the medication that is maintaining his blood pressure & stop the intravenous feeding.
- If you were the Nurse what would you advise? Justify

**CASE EXAMPLE
REFUSAL OF TREATMENT**

- During the medication round, Staff Nurse Emily is faced with Mr. Smith who is refusing to take his medication to control his high blood pressure. Emily understands that she has the obligation to respect the autonomy of her patient, but at the same time she is well aware that the consequences could lead to paralysis.
- What would you do if you were Emily and why?

CASE EXAMPLE

- A 50 year old lady is admitted in your ward for investigation of indigestion, vomiting and weight loss. The reports confirms that she has advanced stage of stomach cancer. The doctor advises surgery to reduce obstruction in the stomach. The husband requests not to disclose the diagnosis as her wife will definitely be much shocked and distressed as she has a phobia about cancer. As the time for surgery is approaching, the patient discloses her fears that the doctor is hiding something and she expresses that you are the only person from whom she can accept the truth. What will you do?

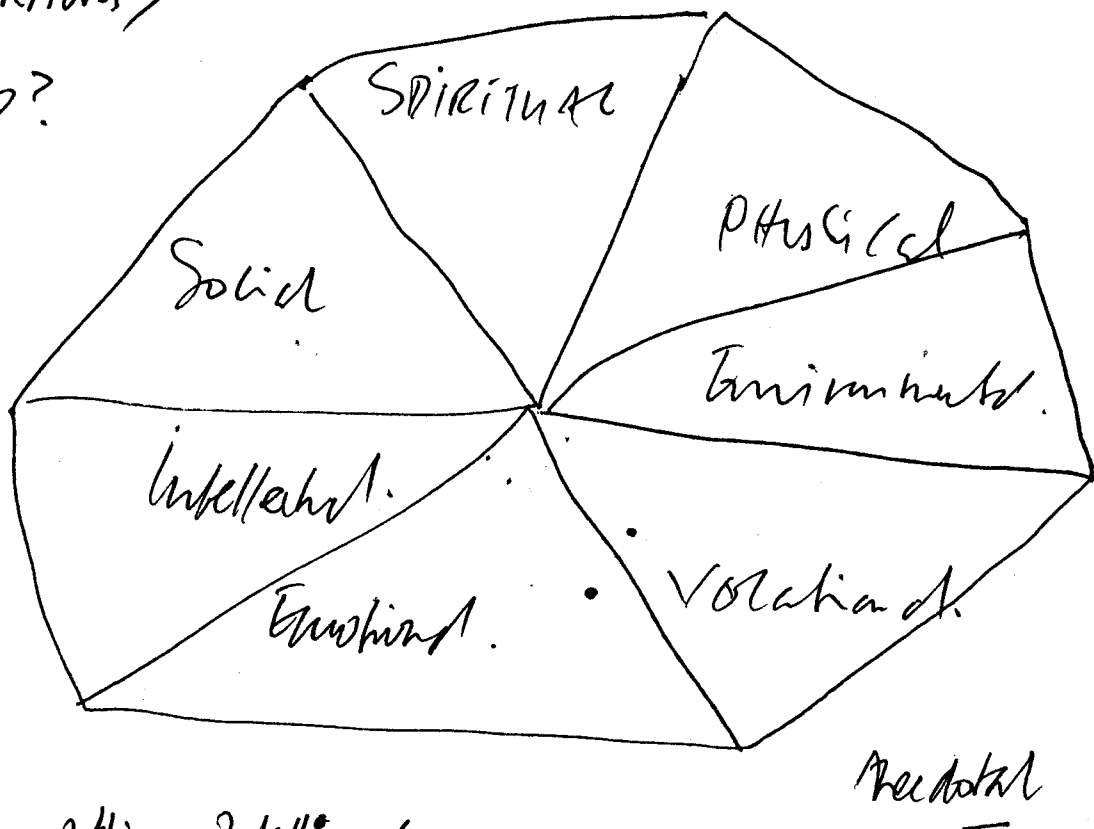
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The determinants of health -

PEERS
Greeting

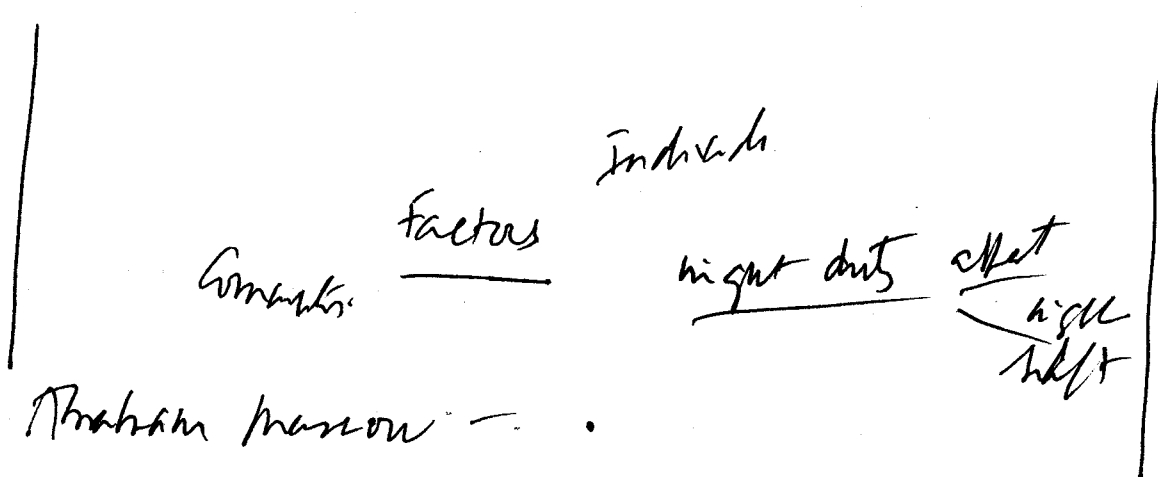
Imbalance - too much K^+ potassium - to
> glucose > hyperglycaemia - > states, &
(conditions)

WHO?



Emotional & Intellectual -

Body and mind interaction leads to health positively & negatively



Abraham Maslow -

NOTE: Assignment for Mr. CHOT

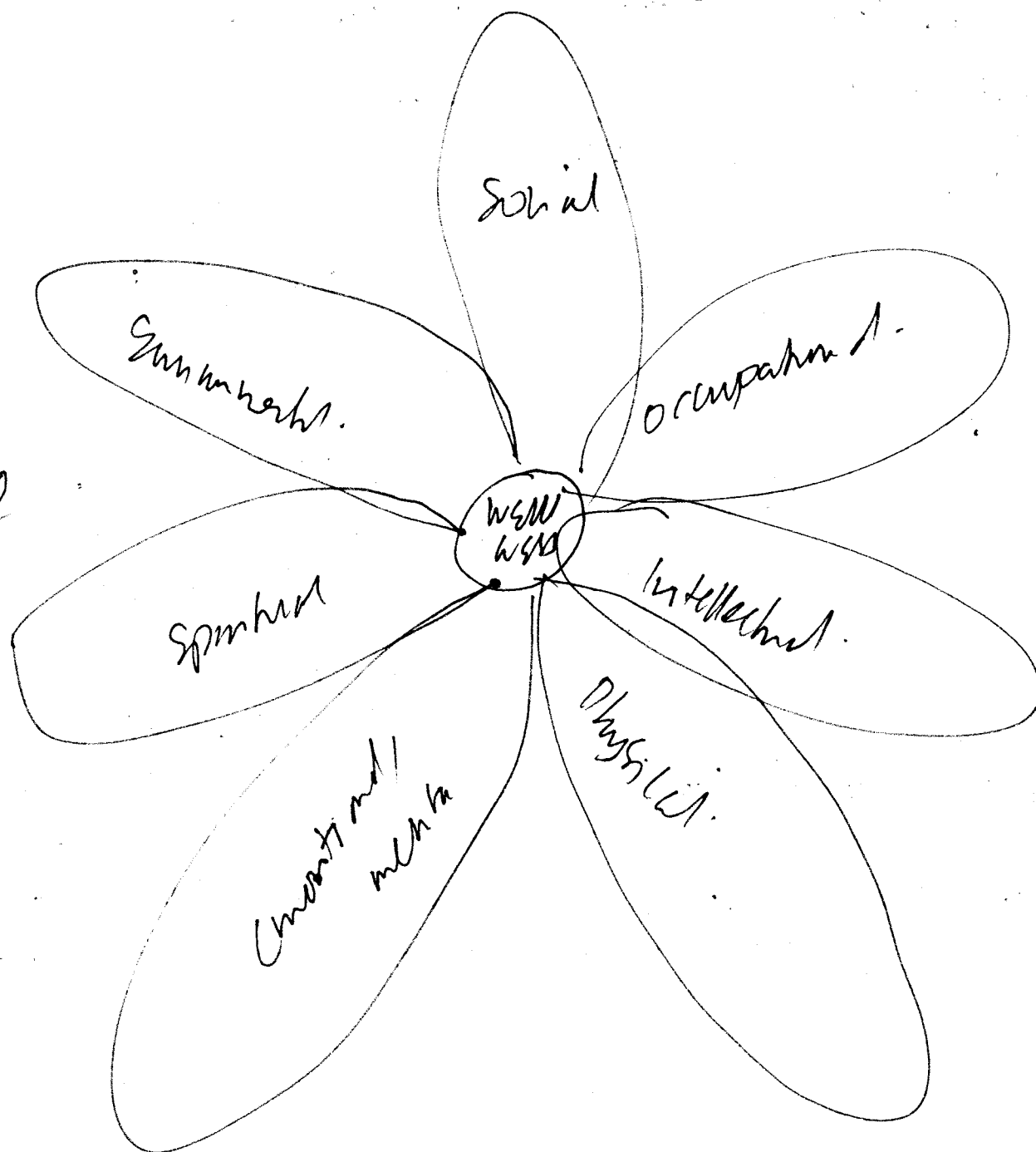
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What is wellness? "Wellness is a multidimensional state of being describes



Existence of positive health in an individual as
expressed through by quality of life and a sense of
well-being. Arizona State University Charles B
Corbin.

Semester 1

YEAR 1

Ca Db $\int_{H_0}^{H_1} f(x) \text{ Hoxing} + \int \dots$ Haralam bosh.

Ca $\int_{\text{Band}}^{\text{cal}+} f(x) \text{ Vit D} \int +$

Sickle Cell Anemia (S(A)) $\int_{D_1}^{H_1} f(x) \text{ Gene} \int \int$

Ing (1m) $\int \text{glues} + \left\{ \begin{array}{l} \text{glues med} \\ \text{date time} \end{array} \right\} + \left\{ \begin{array}{l} \text{change Time} \\ \text{Pulse + Sads} \end{array} \right\}$

+ (sites $\left\{ \begin{array}{l} 1 \\ 4 \end{array} \right\} \left\{ \begin{array}{l} 3 \\ 2 \end{array} \right\}) +$

1. Biological
2. Behavioural
3. Psychodynamics
4. Cognitive
5. Humanistic

code of Behaviour

BEHAVIOURAL PSYCHOLOGY

Behavioural psychologists postulate that behaviour is a product of previous learning. According to early behaviourist theories, learning and behaviour are the result of conditioning. The behaviourist are concerned with learning. They propose that all of a person's behaviour including her personality, is learnt.

Nurs1

Operant conditioning

Nurs 1001

The Heart Disease (HD) NTP

2004 Potential difference (PD) is the difference in HD

potential between two states, points, ranges, conditions
that represents the work made (w_i) treatment (t_j),
the physiological input (v_i) communication input (c_i),
the hardware input (v_i)

or

the hardware input (v_i), part of input (PD)

of a quantity (D) (Heart (H), medicine (m))

trans from one

are

states, case, with (V) -

to another

in the center

1 year of feedback HD -

THEORY of NURSING

Instruction $\int_0^{\infty}$ for 24h duration

2604

ALITV

Inflammet PD $\int_0^H f x^{60} \text{Guttm}^{19m} \text{HLS}$

Inflammet PD $\int_0^H f x_m^{200y} \gamma \text{Guttm}^{19m} T^{1w} \text{HLS}$

Inflammet PD $\int_0^H f x_m^{30y} \gamma \text{Guttm}^{19m} T^{1w} \text{HLS}$

Drach PD $\int_0^H f x_m^{40y} \gamma \text{Guttm}^{24} T^{1w} \text{HLS}$

Drach PD $\int_0^H f x_m^{40y} \gamma \text{Guttm}^{24} T^{1w} \text{HLS}$

Wend PD $\int_0^H f x_m^{10v} \gamma \text{Guttm}^{24} T^{1w} \text{HLS}$

Plenches PD $\int_0^H f x_f^{50y} \gamma \text{Toppins} T^{1w} \text{HLS} + \text{Perrich}^{19} T^{2w} \text{HLS}$

Prescriptive Ambig.

Plenches PD $\int_0^H f a^{50y} \gamma \text{Toppins} T^{1w} \text{HLS} + \text{Perrich}^{19} T^{2w} \text{HLS}$

Weakness PD $\int_0^H f x_n^{18y} \gamma \text{Rest} T^{1w} \text{HLS} + \text{Guttm}^{20m} \text{HLS} = \int_0^H$

Semester 1

Year 1

Nov 11/01
2904

①

NOTES: YOU can't fill to a person how you, you, you -
You needs I also should address people by their Name,

Nursing is the diagnosis and treatment of human responses
to health problems. Nursing is the art of gentle caring.
Nursing is the gentle art of caring.

The health $\times$ disease (HD) potential difference (pd) is
the difference in HD potential between two ^(H) states Health
States and A transfer of a unit or part of a unit of treatment

The HD potential difference between two states
represents the work involved

The HD potential difference between two states,
represents the transfer of a quantity of work or heat

To modify the potential difference is a transfer of a
quantity of work

The potential difference represent two states
the potential difference represent two states

If The potential difference represent the difference in two states

If The potential difference is the work involved between two states

If A nurse manipulates pd (potential difference)

If A nurse adjust pd.

Nursing is the modification of potential difference

Nursing is the modification of potential health $\times$ disease Potential difference
NURSING IS THE MODIFICATION OF HEALTH $\times$ DISEASE potential difference.

aboo.b.s. fatally @ live.com

2904

Nursing fever is the modification of temperature potential difference.

Nursing diarrhoea is the modification of ^{short} intestinal potential difference.

Nursing caring for diabetes is the modification of metabolic potential difference.

Treating infection is the modification of infective vector potential difference.

driving a wheel is the contribution of the wheel wound potential difference.

Nursing action is the modification of ^{short} Pd. Pd.

$Pd = \text{potential difference} - \text{potential difference}$.

~~General~~

The Pd of fever is closed to heat.

The Pd of fever is increased to heat to treat hypothermia. The Pd of hypertension is treated with low cholesterol diet. The Pd of Hx is treated with low cholesterol diet.

The Pd of Hx is the Pd of inflammation is treated by

Pd of inflammation is reported with $\text{Inflammation}^{Pd} = \frac{\text{Inflammation}^{Pd}}{\text{Inflammation}^{Pd}}$

2404

NURSING MTCW S T promo a sens AUTH
 of emot count

- Treatin + die as a chi indiv.
- make confid and priv.

• using touch and personal space in ho.

therapeutic outcome

- Recognizing and respecting cultural differences
- Address anxiety high

Greeting PD $\int_0^+$ + Touch $\int$ + going toward the patient +

glances + anxiety $\int_+$ + Acknowledging +

How to determine intellectual ability - ?

Asides $\int_{0+}^{H-}$ for $\int_{-}^{+}$ (2) calls + {tapping} + $\int_{\text{needle}}$ +

Identify Shyness $\int_{\text{anxiety}}^{\text{Question}}$ +

Empower Empower - let them do by themselves -

LEVELS of PREVENTION

A: Primary prevention :

B: Secondary prevention :

C: Tertiary prevention :

Schizophrenia PD $\int_{\text{Personals}}^{\text{Personals}} + f(x) \text{ mind} + \int_{\text{Personals}}^{\text{Personals}} +$
 + Types of $\sum \left(\begin{matrix} \text{Hesepkran} \\ \text{catkhan} \end{matrix} \right) + (\text{Intend. dialogue}) \int_0^{\infty} f(x) dx +$

Myocardial Infarction PD $\int_{0x-}^{0x+} f(x) + \int_{m0}^{m-} \text{movement} +$

Vulnerable Groups - immunocompromised - homeless -

Study in parts - then practice - put it as whole -

How people perceive help - what you are as nurses!

Role Play

Posters

Nursing is Caring.

12-05-2014 -

Donna - Wms - assistant

MODELS of HEALTH & ILLNESS (MOHI)

Identify the

A: Role Performance Model
 $\begin{matrix} \text{illness} \\ \text{wellness} \end{matrix} \rightarrow \text{health/illness}$

B: Adaptive model - health is seen as adaptive.

C: Endemonistic model. ethics self actualise

D: Ecologic model

E: Enn

Agent Host.

E: TRAN'S model.
intervention.

F: Rosenstock / Becker's Health Belief model.

TREAT EACH Patient as an INDIVIDUAL

1. work level before & after -

2.

1. Demographic Variables

2. Socio-psychological factors

3.

It is not to be a nurse

2904

□ CONCEPT OF HOLISM.

is
+ Treat patient not as per illness. No Homeo
Stans -> illness -

$$\text{Oxygen PD} \int_{D+}^{H-} f x^{\text{boy}} y \text{ Hypothesis} \int_{\text{Hypothesis}-1}^{\text{Hypothesis} 0} \rightarrow \int_{\text{Im}}^{\text{Im}} 1 + f x^{\text{Im}} \text{Im}^{\text{Im}} \\ + T_{\text{daily}}^{\text{Im}} + \text{Met} + \text{Stress} + \text{Lent} + \text{Pressure} \text{ EXOR} - \\ + m \left\{ \begin{matrix} N+D \\ PH+P \end{matrix} \right\} + \int_{\text{ESR?}}^{\text{ESR?}} + \int_{D0.1}^{H0.01}$$

$$\text{Ned} \left\{ \begin{matrix} \text{Somatization} \\ \text{Intelligence} \end{matrix} \right\} + \text{Marking} \left\{ \begin{matrix} \text{Net Ad} \text{ Set} \\ \text{Urban} \text{ Physio} \\ \text{Lent} \end{matrix} \right\} + \left\{ \begin{matrix} \text{Rest of} \\ \text{my life} \end{matrix} \right\}$$

$$\text{Deliberate} \left\{ \begin{matrix} \text{Intake} \\ \text{Exposure to harm} \end{matrix} \right\} \left\{ \begin{matrix} \text{Concentration} \end{matrix} \right\} \\ \left\{ \begin{matrix} \text{Substance} \\ \text{Lent} \end{matrix} \right\}$$

$$\text{Intection PD} \int_{D+}^{H-} f x^{\text{254}} y (\text{Concentration})_{\text{CO}}^{(-)} + T_1^{\text{22}}$$

$$+ \text{Water} \int_0^{\text{Im}} +$$

1015-

basic structure and energy resources, which are protected by lines of resistance, normal line of defense, and flexible line of defense organized in a concentric circle. These lines of resistance and defense and the dynamic relationships among five variables of the system (physiological, psychological, sociocultural, developmental, and spiritual) determine how the client responds to stressors. Nursing's role is to help the client system in relation to stressors, reactions, or reconstitution in the modes of primary, secondary, and tertiary prevention.

[Sources: Neuman, B. (1998). *The Neuman systems model* (4th ed.). Norwalk, CT: Appleton & Lange.]

NEWMAN, MARGARET

Newman developed her theory of health as an expanding consciousness, drawing ideas from Rogers' holistic and unitary view of humans, David Bohm's notion of implicate and explicate orders of universe, and Young's idea of the acceleration of evolution of consciousness. Newman conceptualized consciousness as pertaining to all information of a system that specifies the system's capacity to interact with its environment. Consciousness as the essence of all things that exist, including humans, is embedded within time, reflected in movement. Health as expanding consciousness is manifested in human experiences in time and space, and is expressed as transformation to a more highly organized pattern of the whole. Newman proposed a hermeneutic, dialectic approach to study health and nursing aimed at pattern recognition, and a participatory research engagement that is itself a human experience of transformation.

[Sources: Newman, M. A. (1990). Newman's theory of health as praxis. *Nursing Science Quarterly*, 3, 37–41; Newman, M. A. (1994). *Health as expanding consciousness* (2nd ed.). New York: National League for Nursing.]

OREM, DOROTHEA E.

Orem's general theory of self-care consists of three interrelated sub-theories: the theory of self-care, the self-care deficit theory, and the theory of nursing systems. These theories are founded upon the concept of self-care, which refers to "the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being." The theory of self-care is structured

Psychodynamic Psychology.

This perspective was developed by Sigmund Freud (1858-1939)
 ID - Ego - Super Ego

BEDBATH

PURPOSE:

- Cleanse the skin
- Stimulates circulation
- Provides mild exercise and promotes comfort.
- Allows assessment of the skin condition, joint mobility and muscle strength.

[A partial bath-including hands, face, axillae, back, genitalia, and anal region- can replace the complete bathe for the patient with dry, fragile skin or extreme weakness and can supplement the complete bath for the diaphoretic or incontinent patient.]

EQUIPMENT:

- Bath basin, bath blanket, bath towels, soap [according to client's preference] washcloths,
- Skin lotion, orange stick, gloves, deodorant
- Optional : bath oil, perineal pad, abdominal pad
- Linen saver pad or mackintosh

PROCEDURE:

ACTION	RATIONALE
Preparation of equipment 1. Adjust the temperature of the patient's room. 2. And close any doors and windows. 3. Determine the patient's preference for soap or other hygiene aids	➤ To prevent drafts. ➤ To prevent patient from chilling. ➤ To provide privacy. ➤ Some patients are allergic to soap or prefer bath oils or lotions.
4. Greet the patient. 5. Tell the patient you'll be giving a bath. 6. Explain the procedure. <i>If patient's condition permits, encourage him/her to assist with bathing.</i> 7. Raise the patient's bed to a comfortable working height. 8. Offer him/her bedpan or urinal. 9. Fill the bath basin to-thirds full of warm water [about 115 degrees F or 46 degrees C], and bring it to patient's bedside. <i>If a bath thermometer is not available test water your elbow; the water should feel comfortably warm.</i> 10. If the bed linens will be changed after bath, remove the blanket, if not fanfold it to the foot of the bed. 11. Put on gloves. 12. Position patient supine if possible. 13. Remove the patient's gown and other articles, such as elastic bandages, elastic stockings and restraints [as ordered]. 14. Cover with bath blanket. 15. Place a towel under the patient's chin. Wash face; begin with the eyes farthest from you working from the inner to the outer canthus without soap. Use a separate section of the washcloth for each eye. 16. If the patient tolerates soap, apply it to the cloth, and wash the rest of his/her face, ears, neck using firm, gentle strokes. Rinse thoroughly. Then dry the area thoroughly, taking special care in skin folds and creases. Observe the skin for irritation, scaling or other abnormalities.	➤ To get patient's cooperation. ➤ It provides exercise and promotes independence. ➤ To avoid back strain. ➤ This is a long procedure to avoid disruption during bath. ➤ To avoid scalding or chilling the patient. ➤ To provide warmth and privacy. ➤ To avoid spreading ocular infection.

17. Turn down the bath blanket, and drape the patient's chest with a bath towel. While washing, rinsing, and drying the chest and axillae, observe the patient's respirations.
Use firm strokes.
If the patient tolerates deodorant, apply it.
18. Place a bath towel beneath the patient arm farthest from you. Then bath his arms, using long, smooth strokes moving from wrist to shoulder.
19. If possible, soak the patient's hand in the basin. Clean the patient's fingernails with the orange stick if necessary. Observe the color of his/her hand and nail beds.
20. Follow the same procedure for the other arm.
21. Turn down the bath blanket to expose the patient's abdomen and groin, keeping a bath towel across his chest.
22. Bathe, rinse and dry the abdomen and groin while checking for abdominal distention or tenderness. Then turn back the bath blanket to cover the patient's chest and abdomen.
26. Uncover the leg farthest from you, and place a bath towel under it. Flex leg and bathe it, moving from ankle to hip.
Don't massage the leg.
Rinse and dry the leg.
If possible, place a basin on the patient's bed, flex the leg at the knee, and place the foot in the basin. Soak the foot and then wash and rinse it thoroughly. Remove the foot from the basin, dry it, and clean the toenails. Observe skin condition and color. Repeat the procedure for the other leg and foot.
27. Cover the patient with the bath blanket.
28. Then lower the bed and raise the side rails.
29. When you return, roll the patient on his side or stomach, place a towel beneath him, and cover.
30. Bath, rinse and dry his back and buttocks.
31. Massage the patient's back with lotion, paying special attention to bony prominences.
Check for redness, abrasions, and pressure ulcers.
32. Bathe the anal area from front to back.
Rinse and dry the area well.
33. Change the bath water again after ensuring safety of client.
34. Turn the patient on his back and bathe the genital area thoroughly but gently, using a different section of the washcloth for each downward stroke. Bathe from front to back, avoiding the anal area. Rinse thoroughly and pat dry.
35. If applicable, perform indwelling urinary catheter care. Apply perineal pads or scrotal supports as needed.
36. Dress the patient in a clean gown, and reapply any elastic bandages, elastic stockings or restraints removed before the bath.
37. Remake the bed or change the linens, remove the bath blanket.
38. Return the bed to its original position, and make the patient

- Residual soap can cause itching and dryness.
- To avoid tickling the patient.
- To stimulate venous circulation.
- To soften nails and remove dirt easily.
- To assess peripheral circulation.
- To prevent chills.
- To stimulate venous circulation.
- To avoid dislodging any existing thrombus, possibly causing a pulmonary embolus.
- To assess the peripheral circulation.
- To prevent from chilling.
- To ensure patient safety while you change the bath water.
- To prevent from chilling
- To avoid contamination of the perineum.

comfortable.

39. Carry soiled linens to the hamper with outstretched arms. Remove gloves.

SPECIAL CONSIDERATIONS

40. Fold the washcloth around your hand to form a mitt while bathing the patient. Change the water as often as necessary to keep it warm and clean.
41. Carefully dry creased skin-fold areas- for example, under breasts, in the groin area, and in between fingers, toes and buttocks.
Dust these areas lightly with powder after drying.
42. Use powder sparingly.
43. If the patient has a very dry skin, use bath oil instead of soap. No rinsing is necessary.
44. To move the body joints through their full range of motion during the bath.
45. If the patient is incontinent, loosely tuck an ABD pad between his buttocks and place linen saver pad under him to absorb fecal drainage. Together with these pad will help prevent skin irritation and reduce the number of linen changes.

- To avoid contaminating uniform and spread of microorganisms.
- This keeps the cloth warm longer and avoids dribbling water on the patient from the cloth's loose ends.
- To reduce friction.
- To avoid caking and irritation and to avoid provoking coughing in patients with respiratory disorders.
- To improve circulation, maintain joint and preserve muscle tone

Ebpastorga'11

BACK CARE

PURPOSE:

- Promotes patient relaxation
- Allows assessment of skin condition.

[Particularly important for the bedridden patient, massage causes cutaneous vasodilation, helping to prevent pressure ulcers caused by prolonged pressure on the bony prominences or by perspiration. Gentle back massage can be performed after myocardial infarction but may be contraindicated in patients with rib fractures, surgical incisions or other recent traumatic injury to the back.]

EQUIPMENT:

- Basin, soap, bath blanket, bath towel, washcloth
- Back lotion, with lanolin base, gloves, if the patient has open lesions or has been incontinent
- Optional: talcum powder

PROCEDURE:

ACTION	RATIONALE
Preparation of equipment 1. Fill the basin two-thirds full with warm water. Place the lotion in the basin to warm it.	➤ Application of warmed lotion presents chilling or startling the patient, thereby reducing muscle tension and vasoconstriction.
2. Assemble the equipment at the patient's bedside. 3. Explain the procedure to the patient, and provide privacy. 4. Ask him to tell you if you are applying too much or too little pressure. 5. Adjust the bed to a comfortable working height and lower the head of the bed, If allowed. Wash hands or put on gloves, if applicable. 6. Place the patient in a prone position, if possible, or on his side. Position him along the edge of the bed nearest you. 7. Untie the patient's gown, and expose his back, shoulders, and buttocks. 8. Then drape the patient with a bath blanket. 9. Place a bath towel next to or under the patient's side. 10. Fold the wash cloth around your hand to form a mitt. Then work up lather with soap. 11. Using long firm strokes, bathe the patient's back, beginning at the neck and shoulders and moving downward to the buttocks. Rinse and dry well. 12. While giving back care. Closely examine the patient's skin, especially the bony prominences of the shoulders, the scapulae and the coccyx for redness and abrasions. 13. Remove the warmed lotion bottle/container from the basin, and pour a small amount of lotion into your palm. Rub your hands together to distribute the lotion. 14. Then apply the lotion to the patient's back, using long, firm strokes. 15. Massage the patient's back, beginning at the base of the spine and moving upward to the shoulders. For a relaxing effect, massage slowly; for a stimulating effect massage quickly. Alternate the three basic strokes; effleurage, friction, and petrissage 16. Add lotion as needed, keeping one hand on the patient's back. 17. Compress, squeeze, and lift the trapezius muscle. 18. Finish the massage by using long, firm strokes, and blot any excess lotion from the back of the patient with a towel. 19. Retie patient's gown, and straighten or change the bed linens as necessary. 20. Return the bed to its original position, and make patient	➤ • ➤ To prevent back strain. ➤ To prevent chills and minimize exposure. ➤ To protect bed liens from moisture. ➤ This keeps the cloth warm longer and avoids dribbling water on the patient from the cloth's loose ends. ➤ Trapped moisture between the buttocks can cause chafing and predispose the patient to formation of pressure sores. ➤ The lotion reduces friction, making back massage easier.

comfortable.

21. After care of materials/equipments used.

22. Dispose gloves, if used,

SPECIAL CONSIDERATIONS

23. Before giving back care, assess the patient's body structure and skin condition, and tailor the duration and intensity of the massage accordingly. If you are giving back care at bedtime, have the patient ready for bed beforehand so the massage can help him fall asleep.

24. Use separate lotion for each patient.

25. If the patient has an oily skin, substitute a talcum powder or lotion of the patient's choice. However, don't use a talcum powder if the patient has an endotracheal or tracheal tube in place.

26. Avoid using powder and lotion together.

27. When massaging the patient's back, stand with one foot slightly forward and knees slightly bent.

28. Give special attention to bony prominences.

29. Don't massage the patient's legs unless ordered.

30. Develop a turning schedule and give back care at each position change.

➤ To avoid interrupting the massage.

➤ To help relax the patient.

➤ To prevent cross-contamination.

➤ To avoid aspiration.

➤ This may lead to skin maceration.

➤ To allow effective use of your arm and shoulder muscles.

➤ These areas are disposed to formation of pressure ulcers.

➤ Reddened legs can signal clot formation, and massage can dislodge the clot, causing an embolus.

Ebpastorga'11

PERINEAL CARE

[Includes care of the external genitalia and the anal area, should be performed during the daily bath and, if necessary, at bedtime and after urination and bowel movements.

PROCEDURE:

- Promotes cleanliness and prevents infection.
- Removes irritating and odorous secretions, such as smegma, a cheeselike substance that collects under the foreskin of the penis, and on the inner surface of the labia.

[For the patient with perineal skin breakdown, frequent bathing followed by application of an ointment or cream aids healing. Standard precautions must be followed when providing perineal care, with due consideration given to the patient's privacy.]

EQUIPMENT:

- Gloves, washcloths, clean basin, mild soap,
- Bath towels, bath blanket, toilet tissue, linen saver pad, trash bag
- Bed pan, peri -bottle, antiseptic soap, petroleum jelly, zinc oxide cream,
- Vitamin A and D ointment and abdominal pad

[Following genital or rectal surgery, you may need to use sterile supplies; gloves, gauze, cotton balls]

PROCEDURE:

ACTION	RATIONALE
Preparation of equipment 1. Obtain ointment or cream as needed. 2. Fill the basin two thirds full with warm water. 3. Fill the peri-bottle with warm water if needed. 4. Assemble equipment at patient's bedside and provide privacy. 5. Wash hands thoroughly, put on gloves. 6. Explain to the patient the procedure. 7. Adjust the bed to a comfortable working height and lower the head of the bed if allowed. 8. Provide privacy and help the client into supine position. 9. Place a linen saver pad under the patient's buttocks.	➤ To prevent back strain
PERINEAL CARE FOR THE FEMALE PATIENT 10. To minimize the patient's exposure and embarrassment, place the bath blanket over her with corners head to foot and side to side [diamond drape]. 11. Wrap each leg with a side corner, tucking it under the hip. 12. Then fold back the corner between the legs to expose the perineum. 13. Ask the patient to bend her knees slightly and to spread her legs. Separate her labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum. 14. Avoid the area around the anus, and use a clean section of washcloth for each stroke by folding each section inward. 15. Using a clean washcloth, rinse thoroughly from front to back because soap residue can cause skin irritation.	➤ To protect the bed from stains and moisture.

16. Pat the area dry with a bath towel because moisture can also cause irritation and discomfort.
17. Apply ordered ointment or creams.
18. Turn the patient on her side to Sim's position, if possible.
19. Clean rinse and dry the anal area, starting at the posterior vaginal opening and wiping from front to back.

PERINEAL CARE FOR THE MALE PATIENT

20. Drape the patient's legs and expose the genitalia.
21. Hold the shaft of the penis with one hand and wash with the other, beginning at the tip and working in a circular motion from center to the periphery.
22. Use a clean section of the washcloth for each stroke.
23. Rinse thoroughly, using the same circular motion.
24. For the uncircumcised patient, gently retract the foreskin and clean beneath it.
25. Rinse well but do not dry.
26. Replace the foreskin to avoid constriction of the penis which causes edema and tissue damage.
27. Wash the rest of the penis, using downward strokes to the scrotum.
28. Rinse well and pat dry with a towel. Clean the top and sides of the scrotum; rinse thoroughly and pat dry.
29. Handle the scrotum gently to avoid causing discomfort.
30. Turn the patient on his side.
31. Clean the bottom of the scrotum and the anal area.
32. Rinse well and pat dry.
33. After providing perineal care reposition the patient and make him comfortable.
34. Remove the bath blanket and linen saver pad, and replace bed linens.
35. After care of used materials and dispose of used gloves.

SPECIAL CONSIDERATIONS

36. Give perineal care to a patient of the opposite sex in a matter-of-fact way manner.

- To prevent intestinal organisms from contaminating the urethra or vagina.
- This prevents the spread of contaminated secretions and discharge.
- To expose the anal area.
- To minimize exposure and embarrassment.
- To avoid introducing microorganisms into the urethra.
- To prevent spread of contaminated secretions and discharge.
- Moisture provides lubrication and prevents friction when replacing the foreskin.

37. If the patient is incontinent, first remove excess feces with toilet tissue. 38. Then position him on a bedpan, and add a small amount of antiseptic soap to a peri bottle to eliminate odor. 39. Irrigate the perineal are to remove fecal matter. 40. After cleaning the perineum apply prescribed ointment or cream to prevent skin breakdown by providing a barrier between the skin and excretions. To reduce the number of linen changes, tuck an abdominal pad between the patient's buttocks to absorb oozing feces.	➤ To avoid embarrassment. <i>Ebpastorga'11</i>
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ORAL HYGIENE

PURPOSE

Oral hygiene is provided to maintain the integrity of the client's teeth, gums, mucus membrane and lips.

EQUIPMENT

- Small mackintosh or paper towel
- Face towel
- Small jug
- Water glass with water
- Feeding cup (Facilitates to pour water into the mouth in lying down position)
- Gauze piece in a container
- Emesis basin
- Choose one of the dentifrices according to the need of the client
- Choose one of the solutions for mouth wash
- Choose one of the emollients
- Cotton applicators
- Padded tongue blade (2)- To keep the mouth opened when the client is unconscious or unable do it for himself
- Bowl of clean water to receive the dentures if any
- Suction machine equipment (optional)
- Clean gloves

MOUTH CARE OF A CLIENT WHO IS ABLE TO CARE FOR HIMSELF

PROCEDURE :

ACTION	RATIONALE
1. Wash hands 2. Prepare the mouthwash by adding hot and cold water and drop one crystal of potassium permanganate in to it 3. Pick up the tooth brush , wet it with water ,spread a small quantity of tooth paste on it and hand it over to the client 4. Hold toothbrush bristles at 45 degree angle to gum line. Brush inner and outer surfaces of upper and lower teeth by brushing from gum to crown of each tooth. Clean biting surfaces of teeth by holding top of bristle parallel with teeth and brushing gently back and forth 5. Have client hold brush at 45 degree angle and lightly brush over surface and sides of the tongue 6. When he finishes brushing , pour water on the brush , holding it over the kidney tray and clean the brush thoroughly and put back the brush 7. Allow client to rinse mouth thoroughly by taking several sips of water ,swishing water across all tooth surfaces, and spitting in to emesis basin 8. Allow client to gargle to rinse mouthwash as desired 9. Assist in wiping clients mouth	➤ To prevent cross infection ➤ It act as an antiseptic and deodorant ➤ Wetting the brush makes the bristles soft and prevent tissue injury ➤ Angle allows brush to reach all tooth surfaces and to clean under gum line where plaque and tartar accumulate. Back and forth motion dislodges food particles caught between teeth and along chewing surfaces ➤ Microorganism collect and grow on tongue's surface and contribute to bad breath ➤ Irrigation removes food particles ➤ It leaves a pleasant taste in mouth ➤ Sense of comfort

CARE OF DENTURES

EQUIPMENT:

- Soft bristle toothbrush or denture tooth brush
- Dental cleaning agent or tooth paste
- Glass of water
- Emesis basin sink
- Wash cloth
- Clean gloves
- Denture cup (if dentures are to be stored after cleaning)

PROCEDURE:

ACTION	RATIONALE
1. Fill emesis basin with water or if using sink place wash cloth in bottom of sink and fill sink with an inch of water 2. Remove dentures: if client is unable to do this independently, perform hand hygiene and apply gloves, grasp upper plate at front with thumb and index finger wrapped in gauze and pull downward. Gently lift lower denture from jaw and rotate one side downward to remove from client's mouth. 3. Place dentures on emesis basin or sink 4. Apply cleaning agent to brush , and brush surfaces of dentures 5. Hold dentures close to water. 6. Hold brush horizontally and use back and forth motion to cleanse biting surfaces. Use short strokes from top of denture to biting surfaces to clean outer and inner teeth surfaces 7. Hold brush vertically and use short strokes to clean inner tooth surfaces 8. Hold brush horizontally and use back and forth motion to clean undersurface of dentures	

9. Rinse thoroughly in tepid water 10. If client needs assistance with insertion of dentures moisten upper denture and press firmly to seal it in place. Then insert moistened lower denture. Ask if dentures feel comfortable 11. Keeping dentures moist will prevent warping and facilitate easier insertion. Store in a secure place to prevent loss 12. Remove and discard the gloves 13. Perform hand hygiene	
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FOOT CARE AND NAIL CARE

PURPOSE:

- Promote cleanliness
- Prevents infection
- Stimulate circulation
- Controls odor by removing debris from between toes and under toenails

EQUIPMENT :

- Basin of warm water
- Soap or emollient agent
- Washcloth
- Towels -2
- Toenail clippers
- Nail file ,emery board, pick or orangewood stick
- Skin care lotion or lanolin
- Clean gloves

PROCEDURE:

Action	Rationale
1. Place towel or bath mat on floor in front of client 2. Place basin of warm water on towel 3. Help client place feet in basin. Let feet soak for 10minutes 4. Using a wash cloth , gently wash client's feet with soap and water 5. Dry each foot thoroughly with a second towel. Dry between each toe. 6. Clean underneath and on sides of nails using a orange wood stick	

7. Using nail clippers ,cut straight across the nails, prevent trauma to surrounding tissues 8. Smooth rough edges with an emery board or file 9. Apply lotion to entire foot focusing on dry areas 10. Assist client in putting on clean socks and shoes or slippers AFTER CARE 11. Replace equipment 12. Assist client to bed or position for comfort in chair 13. Clean all the articles used for the procedure 14. Perform hand hygiene 15. Record the procedure on the nurse's record	
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HAIR CARE

Hair care include

- Combing
- Shampooing

HAIR COMBING

PURPOSE

- To keep the hair clean and healthy
- To stimulate scalp circulation
- To remove dead cells and debris
- To distribute hair oils to produce a healthy

EQUIPMENT

- Clean comb with coarse and fine teeth
- Clean towels (2)
- Oil in a container (OPTIONAL)
- Gloves
- Hair ties such as ribbon or a tape
- Mirror

Procedure:

ACTION	RATIONALE
1. Separate the hair in small strands For short hair , comb and brush one side at a time 3. For long or curly hair, turn the patient's head away from you and then part his hair down the middle from front to back 4. If the hair is tangled, hold the strands above the part being combed, so the pull comes on your hand and not on hair roots. Comb the tangles out from the ends first and then go up gradually.	➤ For easy handling ➤ To avoid hurting the patient.

Rub oil on the hair strands to loosen them

Comb and vigorously brush the hair on the side facing you. Then turn the patient's head and comb and brush the opposite side

6. After combing, brush vigorously

7. After combing the hair thoroughly, style the hair as the patient prefers. Braiding long or curly hair helps prevent snarling.

To braid, part hair down the middle of the scalp and begin braiding near the face. Don't braid too tightly.

Fasten the ends of the braids with her ties. Pin the braids across the top of the patient head or let them hang as the patient desires.

8. After styling the hair carefully remove the towel by folding it inward.

AFTER CARE OF THE CLIENTS AND ARTICLES

Clean and tidy up the bed

2. Adjust the position of the client in bed and make the client comfortable

3. Take all articles to the utility room. Clean all the articles and replace them in their proper places

4. Wash hands

5. Record the observations made, if any, and the condition of the scalp and hair on the nurse's record with time and date

➤ To avoid patients discomfort.

➤ So the finished braids don't press against the patient's scalp

➤ This prevents loose hairs and debris from falling on to the pillow or into the patient's bed

SHAMPOOING HAIR

PURPOSE :

- Itching and infection
- Accumulation of dirt and old oils and helps prevent skin irritation
- To promote self esteem

ARTICLES	PURPOSE
• Bath towels-2 • Wash cloth or face towel(2) • Bath blanket • Mackintosh • Shampoo basin /Kelly pad • Cotton balls in a container • Gloves • Shampoo or liquid soap • Hair comb • Basin • Bucket • Pitcher • Jugs (2) • Clean Linen • Hair dryer (according to the hospital policy)	• <i>One to protect the pillow and the other one to dry the hair</i> • <i>To protect the eyes from splattering soap and to dry the face at the end of the procedure</i> • <i>To protect the pillow and bed clothes</i> • <i>To facilitate the drainage of water in to the receptacle</i> • <i>To plug the ears</i> • <i>To collect the dirty water</i> • <i>To Pour Water</i> • <i>One for Hot water and the other for Cold water</i> • <i>To change after Shampoo</i> • <i>To dry the hair after the procedure</i>

PROCEDURE

ACTION	RATIONALE
1. Mix hot and cold water and test the temperature of the water at the back of the hand 2. Wet the hair thoroughly with water 3. Apply shampoo to the scalp. Make a good lather with the shampoo and massaging the scalp with the pads of your finger tips 4. Rinse the hair briefly and apply shampoo again. Make a good lather and massage the scalp as before 5. Rinse the hair thoroughly this time 6. Squeeze as much as water possible to out of the hair with your hand 7. Remove the damp wash cloth from the eyes and cotton balls from the ears 8. Remove the shampoo basin/Kelly pad 9. Dry the hair thoroughly with another towel 10. Spread the hair over the mackintosh and towel placed on the pillow and allow it to dry 11. Make sure client's comfort 12. Assist the patient confined to a comfortable position	➤ Warm water is comfortable and facilitates removal of dirt and sebum ➤ Comfort of the patient and effectiveness of shampoo ➤ To remove all the shampoo
AFTER CARE OF THE CLIENT AND ARTICLES 1. Straighten the bed linen 2. Change the linen if wet 3. Offer hot drink 4. Take all the articles to the utility room. Clean all articles.	

- | | |
|--|--|
| <ol style="list-style-type: none">5. Send the soiled linen in to the laundry. Put back all the articles in their proper places6. Remove the gloves ,Wash hands7. Record the procedure in the nurse's note with time and date.8. Record the abnormalities observed, if any.9. Return to the bed side. When the hair is dry, comb the hair and arrange the hair.10. Remove the mackintosh and towel spread on the pillow.11. Make the client comfortable | |
|--|--|

SHAVING

PURPOSE

- Reducing bacterial growth on the face
- It promotes patient comfort by removing whiskers that can itch and irritate the skin and produce an unkempt appearance

EQUIPMENT

- Shaving kit containing a straight razor or a safety razor
- Gloves
- Soap or shaving cream
- Towel-2
- Wash cloth
- Basin of warm water
- After shave lotion (optional)
- Mirror

ACTION	RATIONALE
1. Put on gloves and fill the basin with warm water. 2. Using the wash cloth, wet the patient's entire beard with warm water. Let the warm cloth soak the beard for at least 1 minute 3. Apply shaving cream to the beard. Or if you are using soap, rub to form a lather 4. Gently stretch the patient's skin taut with one hand and shave with the other holding the razor firmly 5. Begin at the sideburns and work toward the chin using short, firm, downward strokes in the direction of hair growth. 6. Rinse the razor often to remove whiskers. Apply more warm water or shaving cream to the face as needed	➤ to soften whiskers ➤ This reduces skin irritation and helps prevent nicks and cuts

to maintain adequate lather

7. Shave across the chin and up to the neck and throat. Use short and gentle strokes for the neck and the area around the nose and mouth to avoid skin irritation
8. Change the water and rinse any remaining lather and whiskers from the patient's face
9. Dry his face with a bath towel and if the patient desires apply after shave lotion. Remove all the articles from the working area and confined the patient to comfortable position

Using an Electric Razor

1. When using an electric razor, check its cord for any damage that could create an electrical hazard
2. Plug in the razor and apply preshave lotion, if available, to remove skin oils. If the razor head is adjustable, select the appropriate setting
3. Using a circular motion and pressing the razor firmly against the skin ,shave each area of the patient's face until smooth
4. If the patient desires , apply after-shave lotion

AFTER CARE

- Rinse the razor and basin and then return the razor to its storage area
- Wash hands and record the procedure and findings on the nurses record

2014
0705

Elm (s)
Dead (m) t

1344

- 1: Identify the problem
- 2: Gather data.
- 3: Identify options
- 4: Think no ethical problem through
- 5:

Paradigme #

~~pt~~ $pt + N + E + H + A(N/r) = pt + N + E + H + A(N/r)$ — 11/

$$P + N + E + H + A(W/R) + E_3^1 + W^{123} + m_{123} + {}^2J = \text{---} \quad (2)$$

$$P + N + E + H + A(W/R) + E_3^1 + W^{123} + m_{123} + {}^1I \neq$$

$$\text{option}(0) = \text{opt}_{\text{hm}}(0) \quad - (3)$$

Rem) $T + 0 + 1 = 0 + \underline{1} + T(\text{Term})$

$$\text{Alternativ } (A)^n = \text{Alternativ } (A)^n \quad \text{--- (4)}$$

$$A_1 + V_1 \equiv A_2 T(A_1)$$

① Actual - Extreme - $A_{\text{extreme}} (A^S)$ - $A_{\text{mean}} (A^-)$ -
a necessary or life ending substitute -

Enthusiasm = is the act of actively or passively killing

a person particularly for reason of heredity (Eys, 1964). Two types of

2. Plaque factor is the ratio of the number of plaque forming units (PFU) to the number of bacteria in the sample.

Semester 2 in order to allow a person to be a
regulator off -

Year 2

NURS 1008

Conservatoire François Mitterrand.

Jay Seef

Ethics -

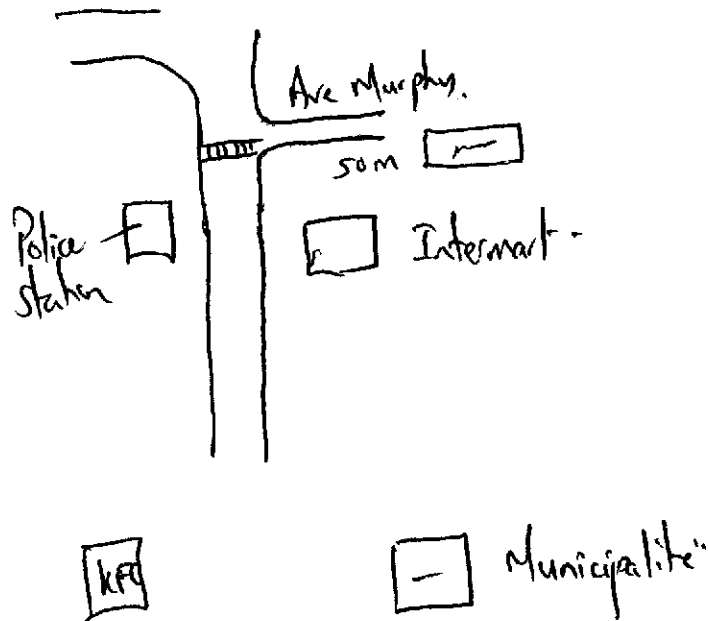
mind

1427

4241012

Quatre Bornes. La Louise

Carrefour



Ethics Committee - key people - discuss & analyse the issue -

Advice from the Legal Department -

An elderly patient with terminal cancer expresses his wish to

die as he can no more bear the long study & painful pain. His family members don't want him to suffer any longer. The doctor is faced with his duty to preserve life & at the same time to attend to suffering. He discusses the issue with the Nurse who has 2 options in mind:

To go with the professional role of ethical practice

Schweitzer 1

YES/NO 1

Return holiday -

① Family agrees -

②a

inflict

fault

Doctors

Mrs

②

inflict

①

① Mr & Mrs meet with fault

①

①

①

Return -

NUM 1000

2-6/10

02-05

Unit 5/6

1. Inflammation

2.

Types of

A. fungus 5

R. bacteria 5

C. virus 5

D. proto 5

Theology - Inflammation

1. Parasites exist in huge variety and include animals, plants, and micro-organisms.

They may live as ectoparasites on the surface of the host (e.g. arthropods such as ticks, mites, lice, fleas, and many insects infesting plants) or as endoparasites in the gut or tissues (e.g. many kinds of worm), and cause varying degrees of damage or disease to the host.

2 derogatory a person who habitually relies on or exploits others and gives

bacteria |bakt'riə|

plural form of bacterium.

bacterium |bakt'riəm|

noun (pl. bacteria |-riə|)

a member of a large group of unicellular microorganisms which have cell walls but lack organelles and an organized nucleus, including some which can cause disease.

Bacteria are widely distributed in soil, water, and air, and on or in the tissues of plants and animals. Formerly included in the plant kingdom, they are now classified separately (as prokaryotes). They play a vital role in global ecology, as the chemical changes they bring about include those of organic decay and nitrogen fixation. Much modern biochemical knowledge has been gained from the study of bacteria, as they grow easily and reproduce rapidly in laboratory cultures.

DERIVATIVES

bacterial adjective,

bacterially adverb

ORIGIN mid 19th cent.: modern Latin, from Greek baktērion, diminutive of baktēria 'staff, cane' (because the first ones to be discovered were rod-shaped). Compare with bacillus.

usage: Bacteria is the plural form (derived from Latin) of bacterium. Like any other plural it should be used with the plural form of the verb: the bacteria causing salmonella are killed by thorough cooking, not the bacteria causing salmonella is killed by thorough cooking. However, the unfamiliarity of the form means that bacteria is sometimes mistakenly treated as a singular form, as in the example above.

NUPH/002

2014.

Types of Cells - Bacteria -

= Bacteria

Prokaryotes

+ (NO nuclear membrane) +

(NO or few organelles)

+ (Circular Chromosome)

Eukaryotes

{ (True nucleus) + (nuclear membrane) } + (linear apoth.)

Human

+ (cell wall)

(linear Chromosome)

Vir. ARCHAEA →

{ unusual bacteria } +

{ double helical }

{ no cell wall } +

{ extreme environment }

{ spores }

= { spore forming bacteria } + { dormant }

Environment

10% bleach - spores are dead -

{ need a host } + { inert }

+ { no chromosomes } + { host }

VI: are OBLIGATE INTRACELLULAR

Parasites

Consist of nucleic acids (DNA) or (RNA) in

a protein coat, called a { CAPSID } + (no cell membrane)

ARE VIRUSES ALIVE? { YES + some characteristics }

(Paramyxovirus) { Polio } + { Cytomegalovirus } +

{ Varicella } + { Rubella virus } + { German measles } +

2014

{ Rotavirus } + { A Influenza } + {

virus |'vaɪrəs|

noun

1 an infective agent that typically consists of a nucleic acid molecule in a protein coat, is too small to be seen by light microscopy, and is able to multiply only within the living cells of a host: the hepatitis B virus | [as modifier] : a virus infection.

- an infection or disease caused by a virus. I've had a virus.
- a harmful or corrupting influence: the virus of cruelty that is latent in all human beings.

2 (also computer virus) a piece of code which is capable of copying itself and typically has

inflammation |'ɪnfleɪ

'meɪʃ(ə)n|

noun [mass noun]

a localized physical condition in which part of the body becomes reddened, swollen, hot, and often painful, especially as a reaction to injury or infection. steroid injections can have a dramatic effect in reducing inflammation and relieving pain. chronic inflammation of the nasal cavities.

ORIGIN late Middle English: from Latin inflammatio(n-), from the verb inflammare (see inflame).

fungus |'fʌŋɡəs|

noun (pl.fungi |-ɡʌɪ, -(d)ʒʌɪ| or funguses)

any of a group of unicellular, multicellular, or syncytial spore-producing organisms feeding on organic matter, including moulds, yeast, mushrooms, and toadstools. truffles are fungi but not mushrooms. [mass noun] : fallen logs were overgrown with bright fungus. [as modifier] : fungus infections like athlete's foot.

- [mass noun] fungal infection (especially on fish). farmed fish often get fungus.
- [in sing.] used to describe something that has appeared or grown rapidly and is considered unpleasant or unattractive: there was a fungus of outbuildings behind the house.

Fungi lack chlorophyll and are therefore incapable of photosynthesis. Many play an ecologically vital role in breaking down dead organic matter, some are an important source of antibiotics or are used in fermentation, and others cause disease. The familiar mushrooms and toadstools are merely the fruiting bodies of organisms that exist mainly as a thread-like mycelium in the soil. Some fungi form associations with other plants, growing with algae to

Assignment
for
wednesday

NOV 1002

2014

0800

0805

worksheet

for Friday

10 min -

Introduction

TO

7 Hours + 1 hour

Microbiology

Bray M. Dege

The study of microscopic organism

1. Discuss the character of diff micro
2. Bacterial Dactin & virus
3. Identify & explain the significance of microorg.

0.01 millimeter
mm -

Are microscopic organism -

light
microscope.

0.01
10 mm

mm -

electron
microscope.

Why study micro? {HIV} TB - small pox #

measles, malaria, cholera, {HIV} H1N1, {Dengue} #.

Covid # MERS CoV # Respiratory # Dengue #

{Chikungunya} # Parvovirus # Tetanus (Tetanus)

150

Known infections Diseases #

Candida Albicans - yeast - [normal flora]

Normal flora - growth goes up in excreta - bacteria.

Immune system drops - disease sets in =

Normal flora are bacteria species - in other places

They cause an infection.

Bacteriology + Bacteria.

Virology + virus

Mycology + fungi

Parasitology + Parasites

Semester 1

①

YEAR 1

$$\{ \text{Gram + Sterility} \} + \{$$
$$\# \{ \text{across} \} + \{ \text{interact} - \text{process} \}$$

(Inn) + (Spine form) (in spine plane) + $\left\{ \begin{array}{l} \text{note sheet} \\ \text{marked -} \end{array} \right\} +$

Drawing

Location:

Function:

{ STRATIFIED SQUAMOUS EPITHELIUM ; KERATINIZED AND NONKERATINIZED }

Be able to distinguish between "keratinized" and "non-keratinized".

Drawing

Location:

Function:

TRANSITIONAL EPITHELIUM

Drawing:

Location:

Function:

PSEUDOSTRATIFIED CILIATED COLUMNAR EPITHELIUM

Drawing:

Location:

Function:

LEVELS OF ORGANIZATION:

A portion of the level of organization of the body, as presented in the text consists of the cell, tissue, and organ levels. Given the following, classify each into the correct level.

stomach

neuron

muscle

epithelium

brain

thyroid gland

skin

bone

cartilage

blood

pancreas

erythrocyte

ANATOMICAL DIRECTIONAL TERMINOLOGY:

For each of the following relationships (A-H), perform exercises 1 and 2

EXERCISE 1. Use a directional term to describe the relationship of the structures as listed.

Directional Terms: superior, inferior; dorsal, ventral; proximal, distal; medial, lateral

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Planes of Reference [median (midsagittal), sagittal, parasagittal, frontal (coronal), transverse (cross-sectional)].

- A. patella (knee cap) is _____ to the sternum:
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- C. cheek is _____ to ear:
- D. ankle is _____ to shin:
- E. elbow is _____ to wrist:
- F. vertebral column is _____ to the umbilicus:
- G. chin (mental region) is _____ to the forehead (frontal region):
- H. nipple is _____ to scapula:

	Exercise 1	Exercise 2
A.		
B.		
C.		
D.		
E.		
F.		
G.		
H.		

II Connective Tissues {Protects and supports the body} and its {organs} {Binds} organs together, {stores} energy reserves. Connective tissue can be classified as:

- I Embryonic Connective Tissue *
 - A. mesenchyme *
 - B. mucous connective tissue *

II Adult Connective Tissue

A. Connective Tissue Proper

1. Loose Connective Tissues

- a. areolar tissue
- b. adipose tissue
- c. reticular tissue*

2. Dense Connective Tissues (collagenous tissues)

- a. dense regular CT
- b. dense irregular CT
- c. elastic tissue*

B. Fluid Connective Tissue

- a. blood
- b. lymph*

C. Supporting Connective Tissue

1. cartilage

- a. hyaline cartilage
- b. fibrocartilage *
- c. elastic cartilage*

2. bone (osseous tissue)

* means you **do not** have to look at or identify this tissue in the lab, but you should know it for lecture.

AREOLAR TISSUE

Identify: elastic fibers (thin), collagen fibers (thick)

List the eight types of cells potentially present in areolar tissue. And a function for each.

Drawing

Locations:

Function:

Function:

Location:

Drawing

[DENSE REGULAR CONNECTIVE TISSUE]

Function:

Location:

Drawing

Identify adipocytes

[ADIPOSE TISSUE]

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Drawing

Locations:

Function:

2014

{ Bacteria } $\rightarrow$ { (unicellular) } + { microorganism } + { divide + (2-3 times/hour) } + { reacts quickly to environment }

{ (E. coli) + (Salmonella typhi) + { Staphylococcus } + (mycobacterium) }
+ { (Bacillus anthracis) + (Pseudomonas) + (1) }
{ (Haemophilus influenza) } + { (Klebsiella pneumoniae) } + {
(Neisseria meningitidis) + (Streptococcus pyogenes) + {

Parts { ① Cell wall [peptidoglycans] + ② The great
target in killing bacteria } + { ③ Adhesin (pili, fimbriae, flagella).
{ (Virulence factors) } + { osmotic gradient } + { Bacillus } +
{ Pili (attach to cells) } + { (Binary fission) } + {
(Classification of Bacteria) $\Rightarrow$ { (Shape { cocci - round, Bacilli - rod +
Spirillum - spiral)

{ (Pair - diplococci) + (Chain Streptococci) + (Cluster Staphylococci) }

OO diplo, O cocci, Bacilli


spore

 Staphylo

Streptococci OOOOOO

① {Nucleic acid} + {RNA or DNA} + {spike proteins} +

{H+Nucleic acid} → Cell → {Protein synthesis mechanism} +

{Assembly} + [{Coded} + {uncoded}] + {(self-limiting)} + {Norman}

② {Hv & B-cell} +

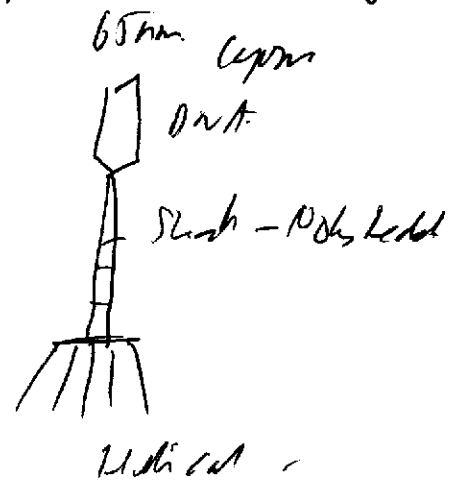
[{Nucleic acid} + {Capsids (Helical + polyhedral)} +

Viral envelope]

{Capsid head → protects head}

{Hosts} + {Species}

{Cell (receptor)}



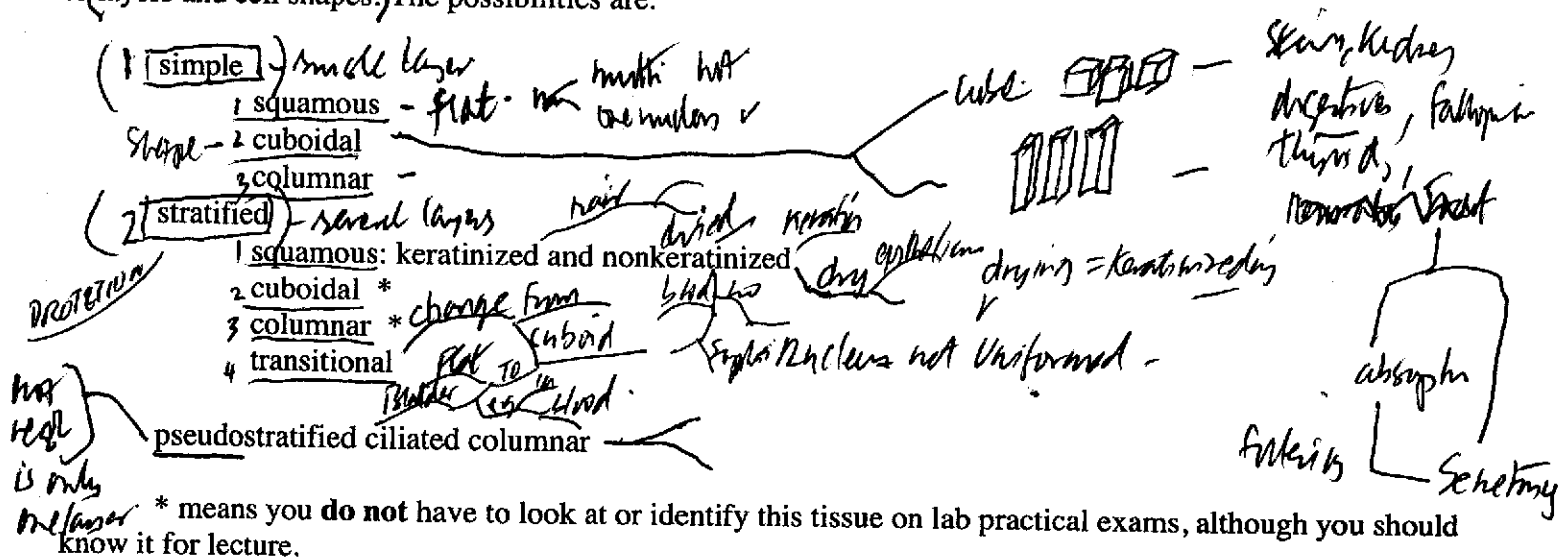
{Viral envelope (from cell membrane) + (host)}
(located by host cell receptor)

(11) Includes but not in (Answer)

{65nm} + {

{Viral load} + {(2)}

I. Epithelium covers body surfaces, lines body cavities, and forms glands. Epithelium is classified according to (layers and cell shapes.) The possibilities are:



SIMPLE SQUAMOUS EPITHELIUM

Drawing:

Location:

Function:

SIMPLE CUBOIDAL EPITHELIUM

Drawing

Location:

Function:

SIMPLE COLUMNAR EPITHELIUM

Personal interests of that we we decide to proceed
into Career

Personal interests of that we we decide to proceed
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TERMINOLOGY AND BODY ORGANIZATION

The body has a ventral cavity, consisting of several subdivisions and containing the internal organs collectively referred to as the viscera. Other minor cavities include nasal, oral (buccal) orbital, middle ear, synovial). Older texts may discuss a dorsal body cavity consisting of cranial and spinal cavity.

Using your text as a reference, name the subdivisions of the ventral cavity that the following organs are located in:

stomach:

pancreas:

liver:

spleen:

lungs:

esophagus:

urinary bladder:

thymus gland:

adrenal glands:

SYSTEMS: List a function of each system below and examples of organs or structures in each.

1. circulatory
2. digestive
3. endocrine
4. skeletal
5. muscular
6. reproductive
7. integumentary
8. nervous
9. respiratory
10. urinary
11. lymphatic

LEVELS OF ORGANIZATION:

A portion of the level of organization of the body, as presented in the text consists of the cell, tissue, and organ levels. Given the following, classify each into the correct level.

stomach

neuron

muscle

epithelium

brain

thyroid gland

skin

bone

cartilage

blood

pancreas

erythrocyte

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E.		
F.		
G.		
H.		

ABDOMINOPELVIC REGIONS & QUADRANTS

Diagram, label the regions, and list several organs or structures in both the 4 abdominopelvic quadrants and in the 9 abdominoplevic regions. Yes, you'll need two separate diagrams. ☺ .

I. **Epithelium** covers body surfaces, lines body cavities, and forms glands. Epithelium is classified according to layers and cell shapes. The possibilities are:

simple

squamous

cuboidal

columnar

stratified

squamous: keratinized and nonkeratinized

cuboidal *

columnar *

transitional

pseudostratified ciliated columnar

* means you **do not** have to look at or identify this tissue on lab practical exams, although you should know it for lecture.

SIMPLE SQUAMOUS EPITHELIUM

Drawing:

Location:

Function:

SIMPLE CUBOIDAL EPITHELIUM

Drawing

Location:

Function:

SIMPLE COLUMNAR EPITHELIUM

Drawing

Location:

Function:

STRATIFIED SQUAMOUS EPITHELIUM ; KERATINIZED AND NONKERATINIZED

Be able to distinguish between "keratinized" and "non-keratinized".

Drawing

Location:

Function:

TRANSITIONAL EPITHELIUM

Drawing:

Location:

Function:

PSEUDOSTRATIFIED CILIATED COLUMNAR EPITHELIUM

Drawing:

Location:

Function:

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Locations:

Function:

ADIPOSE TISSUE

Identify adipocytes

Drawing

Location:

Function:

DENSE REGULAR CONNECTIVE TISSUE

Drawing

Location:

Function:

DENSE IRREGULAR CONNECTIVE TISSUE

Drawing

Location:

Function:

HYALINE CARTILAGE

Identify: chondrocytes, lacuna, perichondrium

Drawing

Locations:

Function:

OSSEOUS (BONE) CONNECTIVE TISSUE

Identify: lacuna, osteocyte, lamella, central (Haversian) canal, perforating (Volkmann's) canal, canaliculi

Drawings:

Locations of all items:

Functions of all items:

Statement of account

VAT Reg. No.: VAT20070778

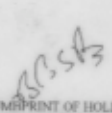
Business Reg. No. : C06006834

FATALLY ABOO BAKAR SIDICK
127 DIEGO GARCIA ST
PORT-LOUIS

Date of bill: 11/04/2014
Month: MARCH 2014
Period: 07/03/2014 - 06/04/2014
Customer Acc. No.: 00268966
Line number: TLP 2170564
Bill number: 4038-034091

Balance on previous bill:	0.00
Amount debited:	0.00
Payments received/credit adjustments:	0.00
Amount still due as at: 11/04/14	0.00

Charges for the period		VAT %	
Detailed rental	Start date End date		
Telephone line rental	07/04/2014 06/05/2014	0	90.00
My.T 1M + TV	07/04/2014 06/05/2014	15	838.26
Tickets	Date		
VAT (MyT) Refund	06/04/2014	0	-15.00

Government of Mauritius
NATIONAL IDENTITY CARD
SURNAME: **Fatally**
FIRST NAME: **Abou Bakar Sidick**
MAIDEN NAME:
DATE OF ISSUE: **04-MAY-12**
BLOOD GRP:
ISSUING AUTHORITY SIGNATURE: 
ID No. **F1806520125397**
SIG / THUMBPRINT OF HOLDER: 

Abou Bakar Sidick Fatally
Student Nurse

Student ID : ABNS1405011

Total amount due 0.00

INFORMATION AND PAYMENT RULES ON THE BACK OF THIS FORM

PAYMENT VOUCHER

This voucher should accompany your remittance

Month: MARCH 2014
Name of customer: FATALLY ABOO BAKAR SIDICK
Customer account number: 00268966
Line number: TLP 2170564

Date of bill: 11/04/2014
Bill number: 4038-034091
Arrears: 0.00
Current bill: 1039.00
Total amount due: 0.00

2014
0605

A: Skin - Normal flora -

B: ~~NO~~ Bomb removes normal flora -

C: Vaso dilation - Vasoconstriction -

D: Compress & contract x ice x constriction -

E:

It secretes Sebum on only substance that softens and lubricates the hair and skin, prevent the hair from becoming brittle. fat is a poor conductor of heat - Sebum has a bacteriostatic action. It transmits sensations through nerve receptors. Arteriole rays activate a vitamin D precursor present in the skin -

> Sudoriferous glands sweat glands - 2 to 5 million
palm & soles - has most sweat glands - So

> apocrine, eccrine

> apocrine located in axillae & anogenital areas.

NURS

SAFETY & SECURITY OF PATIENTS - JCI

FECH

OSDS

2014

0815

WEBSITE
included
for assign

OBJECTIVES :

- * Identify age-related safety factors
- * To have an insight of what safety precautions to be taken for patient with medical problems
- * Be aware of common environmental hazards and what necessary precautions are required
- * The physical changes of aging are universal, but the pace at which they occur is highly individual, depending on genes, age, sex, race, environment, and life style. Some people look and feel old at 60 or earlier, while others remain youthful in health, appearance, and attitude at 70 and beyond.

The challenge for health professionals is to distinguish between normal age-related changes and symptoms of a disease or disorder that requires preventative or therapeutic action.

Groups at Risk $\neq$ Factors $\neq$

Group (G) + Risk (R) + Factors (F) + Intervention (I) =

GROUP (G) + RISK (R) + FACTORS (F) + INTERVENTION (I)

G + R + F + I = G + R + F + I

Assignment on Safety & Security of Patients

Semester I

YEAR I

NURS100
0505
2014
0925

PSC#

Age-related changes affect the function of
the system -

- > Heart output declines
- > Calcium migrates from bones & teeth into blood vessels
- > Cataract & dim Vision, Hearing, Arteries, Lung, liver, and Kidney.

1007

- # Nutrition # Integument # Sensation # Respiration # Gastrointestinal # Musculoskeletal # Neurological # Cardiovascular # Push hard to avoid heart infection # Never!!! However, medical history should include -
- # Age nursing intervention # physical assessment #
- What nursing intervention required - check with the nurse.
- 1: Time: Long no breeze - Int
 - 2: Interv:
 - 3: How long: after open. 5: Learning disabilities.
 - 6: Risk Assessment
 - D: As they age. As they age.
 - C: Falling - Risk factors -
 - D: Consequences of those who have a fall.

Semester 4

Ngm 2

REDUCING THE RISK OF FALLING -

Psychological Aspects -

Human Rights Act # says not to harm -

Restraint: Physical, medical chemical, Environmental

1048 Dominated -

1: Areas 2:

1: What is the first thing you will do?

A: Check if conscious -

2: What is the role of the hospital nurse?

A: Should do a complete admission, complete history, complete physical, before they leave.

B: A complete a patient nurse to complete the work.

B: It was left all unattended -

D: Side cant say PROCEED

4. What steps by step procedure to get to the lower floor
the what step

A: Paper ladder,

can for help # Recontact Area

Nursing

0808

Past

1: It needs proper medication -

IPSC

Patient Identification

Universal Protocol

Reserve Infection

Improve Communication

Medication Safety

Falls Prevention

Assignment
Two weeks

Role of Registered Nurse

Q First #
Group =

First Seen
Group of 4

Safety and Security of patient are vital in hospital
Environment =

Home

Identify

As a student how would you identify
higher risk patients and what safety measures

can be considered and implemented? Went home
del.

12.05 = 2014

Type 1

Humanistic psychology

Aim: to give students an overview of humanistic psychology and its relevance to nursing practice.

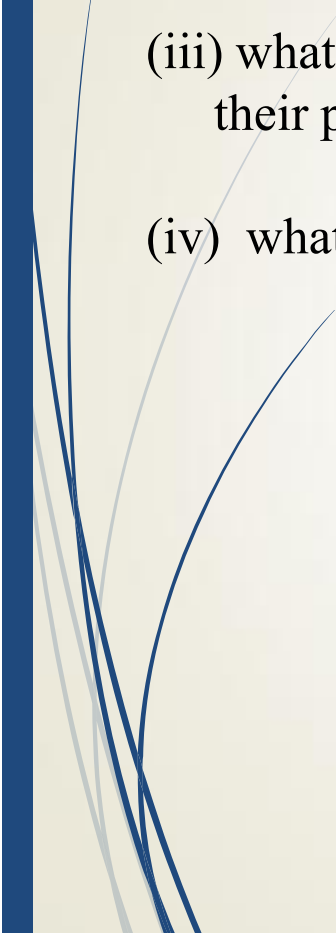
Objectives/Learning outcomes.

- (i) Students will understand the concept of holistic care, that is the principles of person-centred care.
- (ii) Students will understand the terms empathy, unconditional positive regard and how the nurse can apply this to the nurse-patient relationship.



(iii) what empowerment is and how the nurse can empower their patients.

(iv) what the role of a patient advocate entails.



Activity

Look at your priorities in your holistic assessment of the health needs of a person.

Are they the same as Maslow's ? If not, why not?





Dr Carl Rogers (1902 – 1987)



Humanistic psychology emerged during the 1950s, in reaction to both the behaviourist and psychodynamic schools within psychology. The humanistic perspective strives to highlight a more holistic vision of both psychology and the understanding of the person. The aim of humanistic psychology is to understand 'the person' and the actual 'lived experiences' of the individual as well as planning therapy, care and treatment around the patient.



This approach highlights the importance of patient-centred care when any change is needed for the patient to better manage their illness or get better.

Other aspects of humanistic psychology include **empowerment**, which can be defined as having control and confidence over one's life and when interacting with others, and **advocacy**.



Carl Rogers emphasized the client/patient being the most important resource when attempting to help them.

Rogers highlighted the importance of three core conditions as being central to understanding the client:

- genuine and congruent
- offering unconditional positive regard and total acceptance
- feel and communicate a deep empathetic understanding which facilitate patient-centredness.



Unconditional positive regard – defined as not judging a patient within the nurse-patient relationship, irrespective of their illness, lifestyle or previous lifestyle/medical history.

The nurse needs to talk to the patient without any conditions and judgments placed on the patient. These are necessary conditions in order for the patient to initiate change and to move out of their present mindset. Rogers refers to moving on as **self-growth**.

Unconditional positive regard

It can be defined as, ‘ a label given to the fundamental attitude of the person-centred counsellor towards her client. The counsellor who holds this attitude provides care for the individual irrespective of what beliefs and values the individual (patient) may hold. The attitude manifests itself in the counsellor’s consistent acceptance of and enduring warmth towards her client. (Mearns and Thorne 2005 cited in Rana and Upton 2009,p.54).

According to James Bugental (1964) cited in Rana and Upton 2009,p.56, five main principles underpin humanistic psychology.

- human beings cannot be reduced to components.
- human beings have in them a unique human contexts.
- human consciousness includes an awareness of oneself in the context of other people.
- human being have choices and responsibilities.
- human beings are intentional; they seek meaning, value and creativity.

Empathy can be defined as: a continuing process whereby the counsellor lays aside her own way of experiencing and perceiving reality, preferring to sense and respond to the experiences and perceptions of her client. Sensing may be intense and enduring with the counsellor actually experiencing her clients's thoughts and feelings as powerfully as if they had originated in herself.
(Mearns and Thorne 2005 cited in Rana and Upton 2009,p54).

Sympathy and empathy – what is the difference?

Sympathy can be defined as ‘ an expression of the caregiver’s own sorrow at another’s plight’ (Morse et al., 2006 cited in Rana and Upton 2009,p.61). Empathy removes the listener (nurse) from becoming emotionally involved and keeps the listener at an emotional distance whilst attempting to understand what the speaker (patient) is feeling.

The third component that Carl Rogers highlights is **congruence**.

Congruence can be defined as: the state of being of the counsellor when her outward responses to her client consistently match the inner feelings and sensations, which she has in relation to the client. (Mearns and Thorne 2005 cited in Rana and Upton 2009,p.55)



Abraham Maslow – five-stage hierarchy of needs model

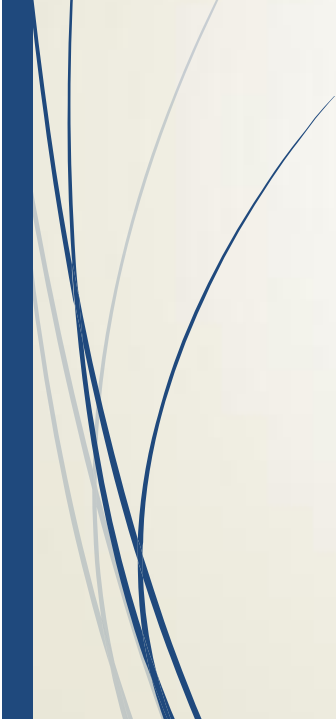
Abraham Maslow's hierarchy of needs

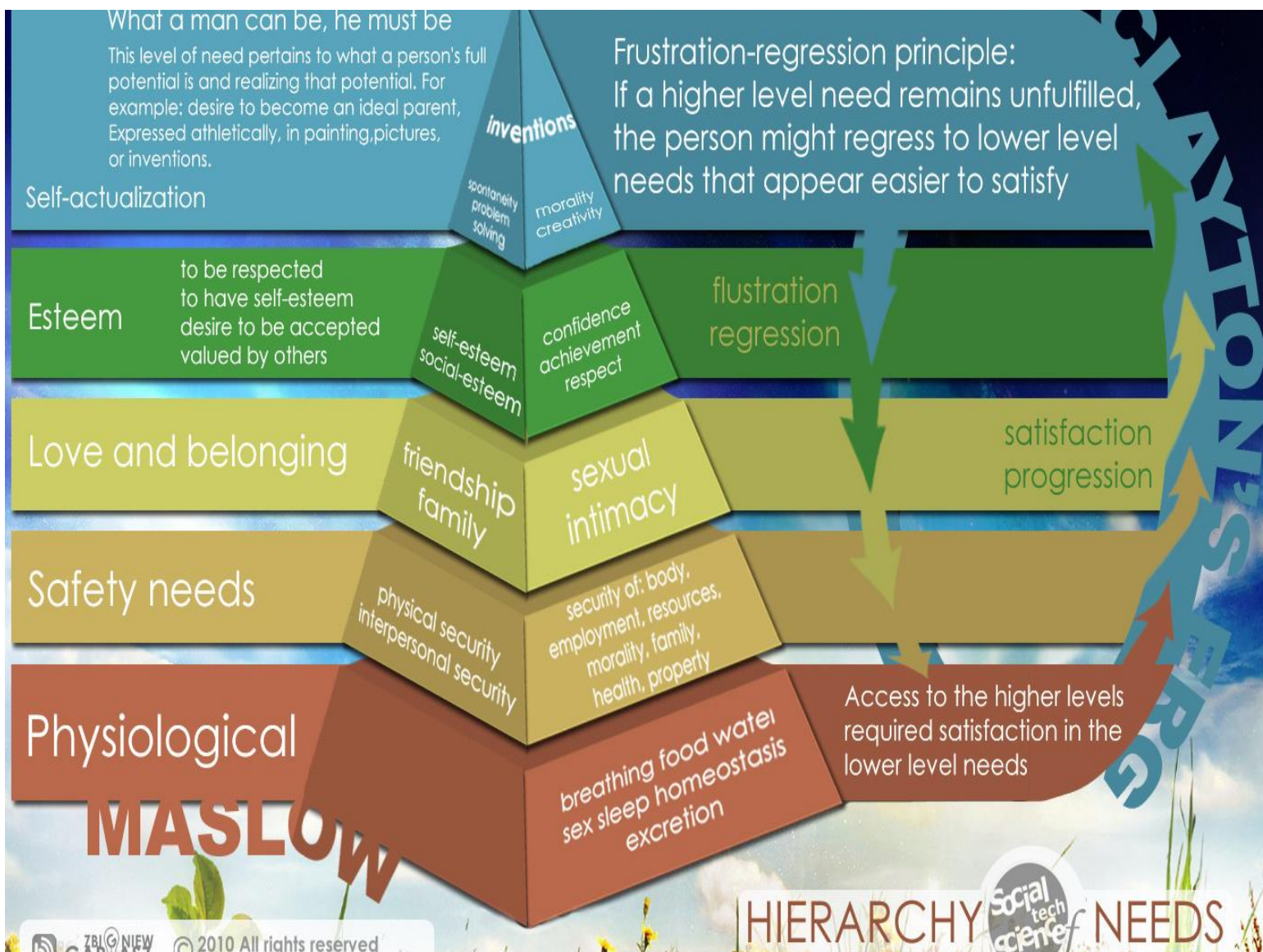
Maslow (1908-1970) is one of the founding pioneers of humanistic psychology. His most famous contribution is the five-stage hierarchy of needs model, which explores how human beings can be motivated and reach eventual self-actualisation, the best that one can achieve.

Maslow proposed the idea that growth needs – higher-order needs of a human being such as aesthetic, cognitive and self-actualisation needs cannot be met unless the basic needs of a human being have been satisfied.



These basic needs are referred to as deficiency needs, such as physiological, esteem, love and belonging, and security and safety needs.





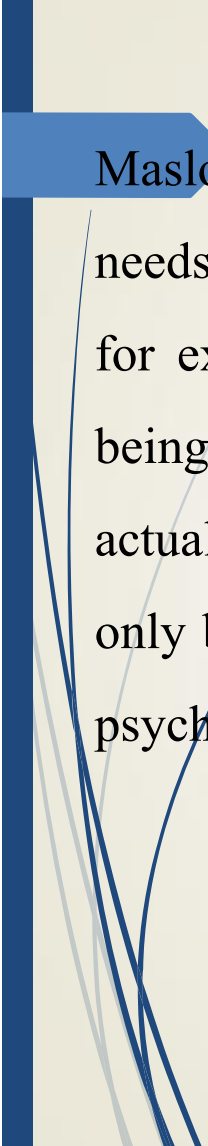


According to this model, basic needs need to be met before an individual can achieve **self-actualization** the peak need level.

Self actualization can be defined as ‘the need to find fulfillment and realize one’s potential (Watkinson and Scott 2004 cited in Rana and Upton 2009,p.55).



Self-actualization is considered to be the healthiest mental state for human beings and represents the peak of humanistic psychology according to [Abraham Maslow's hierarchy of needs](#). Those who are self-actualized have reached their highest individual potential; as Maslow described it, they have “the full use and exploitation of talent, capacities, potentialities, etc. Those in humanistic psychology believe that all humans are capable of self-actualization, although they sometimes need guidance to understand and navigate their own hierarchy of needs.



Maslow categorized needs into deficiency needs and growth needs, the first being needs that arise in order to fill a deficiency, for example, food, sleep and basic security in life. The second being needs that fulfill a desire for personal growth, are self-actualizing needs. The concept of self-actualization was touted not only by Maslow, but also by another leading figure in humanistic psychology, Carl Rogers.



He developed what is now the most commonly used form of therapy, in which the therapist creates a welcoming and non-judgmental environment for the patient to talk about his or her problems.



Conclusion

The basic principles and concepts such as empathy, congruency and unconditional positive regard are key to the understanding of patient-centred care.

I thank
you!



Table 1.2 Most commonly identified mental defence mechanisms. Adapted from Gross (2001), p. 624, Table 42.5.

Name of defence mechanism	Description	Example
Repression	Forcing a threatening memory/feeling/wish out of consciousness and making it unconscious	You feel sexually attracted to one of the people you are caring for but force this desire out of your consciousness
Displacement	Transferring feelings from their true target onto a harmless substitute target	One of the other members of the multi-disciplinary team keeps interrupting when you are trying to inform a patient about a health issue, but instead of dealing with them you go home and shout at your partner
Denial	Failing/refusing to acknowledge/perceive some aspect of reality	This can be observed when a patient refuses to accept that they have a serious illness
Rationalisation	Finding an acceptable excuse for some unacceptable behaviour	A client you have been supporting at great emotional expense makes a complaint about the amount of support they are receiving. You feel angry but rationalise their behaviour as being due to their ill health
Reaction-formation	Consciously feeling/thinking the opposite of your true (unconscious) feelings/thoughts	You strongly dislike one of your nursing colleagues so become extremely considerate/polite to them – even going out of your way to be nice to them
Sublimation	A form of displacement in which a substitute activity is found as a way of expressing some unacceptable impulse	You have been trying for the whole shift to make a telephone referral but each time the telephone has been engaged; at the end of the shift you feel very frustrated and so take yourself to the gym
Identification	Incorporating/introjecting another person into one's own personality – making them part of oneself	You are working in the accident and emergency department and a woman comes in who has been raped. When you suggest she speaks to the police she refuses as she believes the man was frustrated and she had encouraged him by wearing revealing clothes
Projection	Displacing your own unacceptable feelings/characteristics onto someone else	You find you are not able to relate to one of your patients and instead of saying you do not get on with them you say that they do not get on with you
Regression	Reverting to the behaviour characteristic of an earlier stage of development	When asked to clean the clinic room for the second time that day you lose your temper
Isolation	Separating contradictory thoughts/feelings into 'logic tight' compartments	A patient has taken their own life but you talk about it without any display of emotion

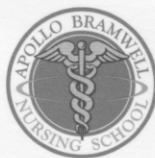


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A member of the British American Investment Group of Companies

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Table 1.2 Most commonly identified mental defence mechanisms. Adapted from Gross (2001), p. 624, Table 42.5.

Name of defence mechanism	Description	Example
Repression	Forcing a threatening memory/feeling/wish out of consciousness and making it unconscious	You feel sexually attracted to one of the people you are caring for but force this desire out of your consciousness
Displacement	Transferring feelings from their true target onto a harmless substitute target	One of the other members of the multi-disciplinary team keeps interrupting when you are trying to inform a patient about a health issue, but instead of dealing with them you go home and shout at your partner
Denial	Failing/refusing to acknowledge/perceive some aspect of reality	This can be observed when a patient refuses to accept that they have a serious illness
Rationalisation	Finding an acceptable excuse for some unacceptable behaviour	A client you have been supporting at great emotional expense makes a complaint about the amount of support they are receiving. You feel angry but rationalise their behaviour as being due to their ill health
Reaction-formation	Consciously feeling/thinking the opposite of your true (unconscious) feelings/thoughts	You strongly dislike one of your nursing colleagues so become extremely considerate/polite to them – even going out of your way to be nice to them
Sublimation	A form of displacement in which a substitute activity is found as a way of expressing some unacceptable impulse	You have been trying for the whole shift to make a telephone referral but each time the telephone has been engaged; at the end of the shift you feel very frustrated and so take yourself to the gym
Identification	Incorporating/introjecting another person into one's own personality – making them part of oneself	You are working in the accident and emergency department and a woman comes in who has been raped. When you suggest she speaks to the police she refuses as she believes the man was frustrated and she had encouraged him by wearing revealing clothes
Projection	Displacing your own unacceptable feelings/characteristics onto someone else	You find you are not able to relate to one of your patients and instead of saying you do not get on with them you say that they do not get on with you
Regression	Reverting to the behaviour characteristic of an earlier stage of development	When asked to clean the clinic room for the second time that day you lose your temper
Isolation	Separating contradictory thoughts/feelings into 'logic tight' compartments	A patient has taken their own life but you talk about it without any display of emotion



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COPING MECHANISM

{COPING + STRATEGIES} $\Rightarrow$ {(NURSING) + (Application of knowledge)}

[{What is it, what is it; help others with problem?} $\Rightarrow$ {REHABILITATION}]

{(An innate) + (an acquired)} $\Rightarrow$ {(way) + {of responding} + {to a changing} +
 {environment} + {or} + {specific problem} (or) + {situation}?, ?} + {Folkman}

{Lazarus (1991)} + {Lupton & Rona} + {Coping} + {cognitive} + {or}

{behavioural} + {effort} + {to manage} + {(specific)} + {external} + {or}

+ {or} + {or} + {internal} + {demands} + {that} + {one appraised} + {or}

{exceeding} + {the resources} + {for the person}.

Two types + (problem focused) $\propto$ (emotion focused coping) + {effort} +

{to improve} + {or} + {or} + {Long term} + {Short term} + {strategies} +

Emotion $\Rightarrow$ (Short term) $\Rightarrow$ {(reduce) + (stress)} + {(to tolerate) + (limit)}

{(temporary)} + {(ineffective)} + {(way) + {(to deal) + (with reality)}. {They

even} + {have} + {a destructive} + {dehabilit} + {(effect) for the person} +

{(e.g.) + {(alcoholic beverages) + or + (drugs), {the cheating} + (and) +

fantasies, relying on a belief that was not everything was will work at.

0805
2014

{ } + { (approach) + (stress) + (adapt) } + { (avoid) + (stress) }
+ { reappraisal of the situation } + { }

{ } { coping } + { (can) + (be) } + { adaptive } + { or } + { maladaptive } + { }

(1) { Adaptive coping - does effectively } + { with stressful event } + { and } +

{ minimize distress associated with being } + { }. { Maladaptive } + { }

{ (coping) - results } + { in distress } + { effective } + { coping results in } + { }

{ Adaptation } + { coping is always } + { purposeful } + { } - (1)

[DEFENCE MECHANISM]

{ (1' stress) + (Denial) + (NURSES) + { Defence } + { (mechanism) } +
(tailor) + (communication) + { patient } + { feel } + { comfortable } +
{ to talk } + { about their feelings } + { CATHARSIS } + { where an individual } +
{ individual is able to discharge } + { their emotions, } + { feelings }
{ and } + { thoughts }, { catharsis } + { flight } + { fight } + { either } +

{ You kill me } + (or) + { I kill you } + { } / { Denial } + { Regression }

{ Denial } + { is } + { (re)petition } / { Regression } + { (Reversion) + (to an) +
(earlier stage) + { of development } + { in the face } + { of unpleasant } +
{ thoughts or impulses } .

NURS1003

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p805
14/45

(REGRESSION)

{Adult} + {regress} + {under} + {stress} + {refusing} +
 {leave} + {their} {bed} + {to engage} + {in} + {normal} +
 {every day} + {Activities} -

(ACTING OUT) (AO)

(AO is) + {performing} {an extreme behaviour} + {in order to}
 {express} + {thoughts} + {or feelings he person feels} +
 {in capable of} + {otherwise expressing}.

Nurs 1003-

Chet Hub

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#605

Humanistic psychology is to understand 'the person' and be attuned 'lived experiences' of the individual as well as planning therapy, care and treatment around the patient.

EMPOWER -

To give people the power to do -

Carl Rogers - Client/patient "most responsible person"

> genuine and congruent

> offering unconditional positive regard
total acceptance

James

ROBERTHAT

Means - Thorne 2005

Reinforcement 2009/54

deep empathetic understandings which
foster patient-centered care.

In counseling the counselor whatever presents as you
should do this, should do that, etc.

C#T#A#

To-morrow never comes, can you ask him to come
and see us to-day. He will never come

(Means and Thorne 2005 citation in Rane and Apter 2004
1954 -)

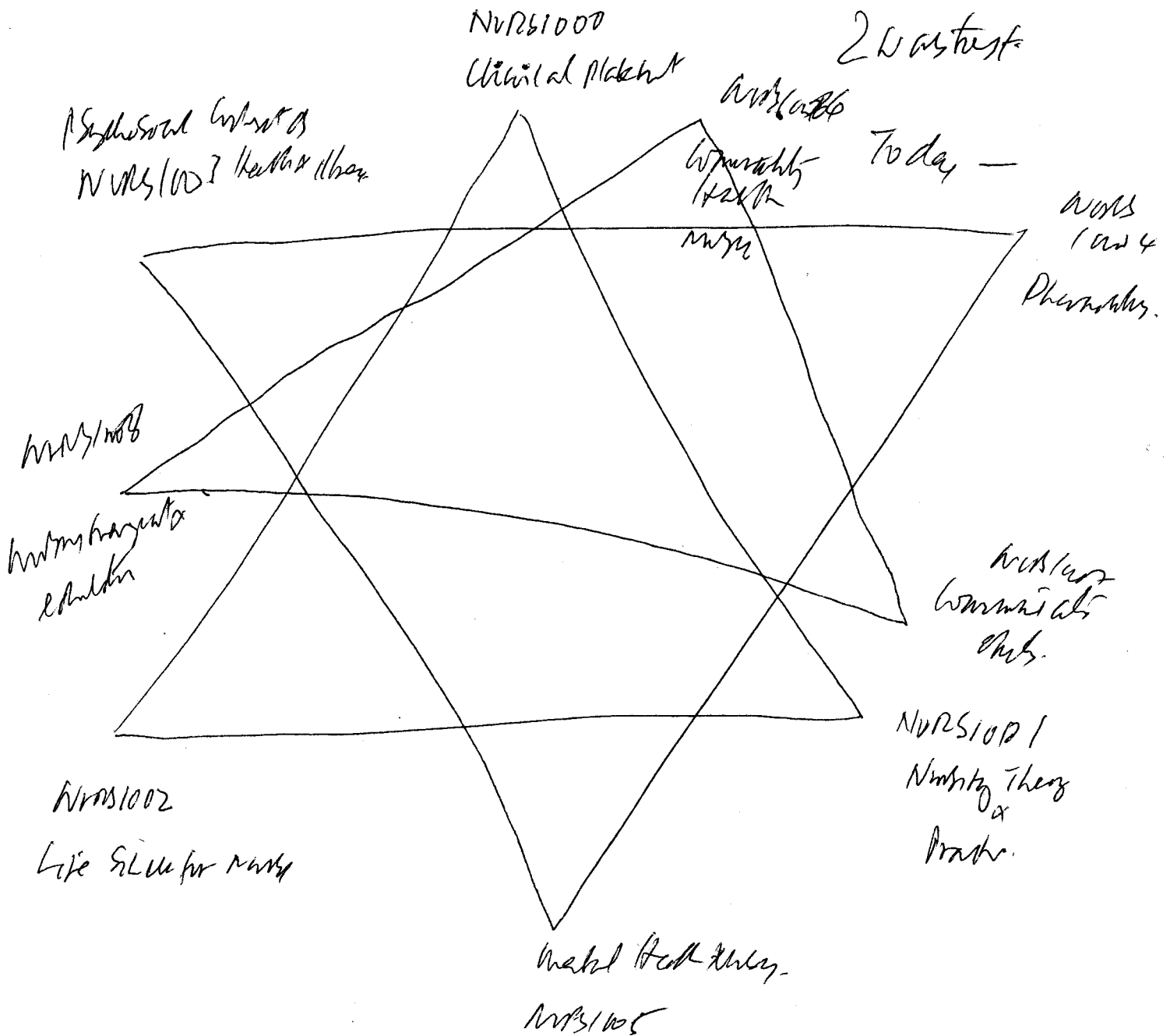
Semester 1

1/1/16

$P + NTP + psy + m + L + O + Pha + LSA + ME$

G. B
3T 3T
3B/3S
un 1T

2 wastest



$$\{ P + NTP + (psy + m + com) + com + (Pha + LSA) + ME \}$$

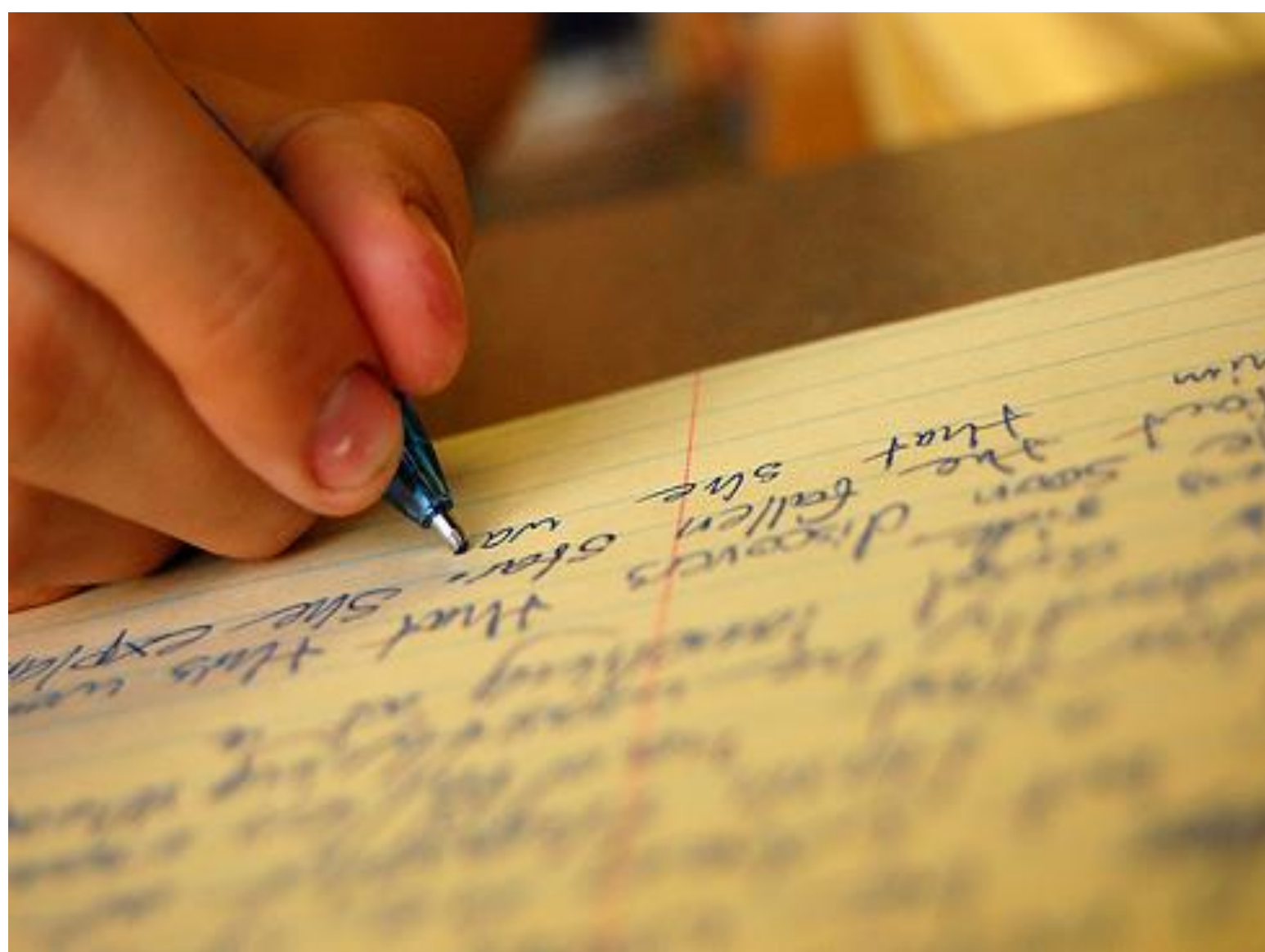
$$\{ (P + ME + NTP) + (psy + m + com) + (Pha + LSA + P) \}$$

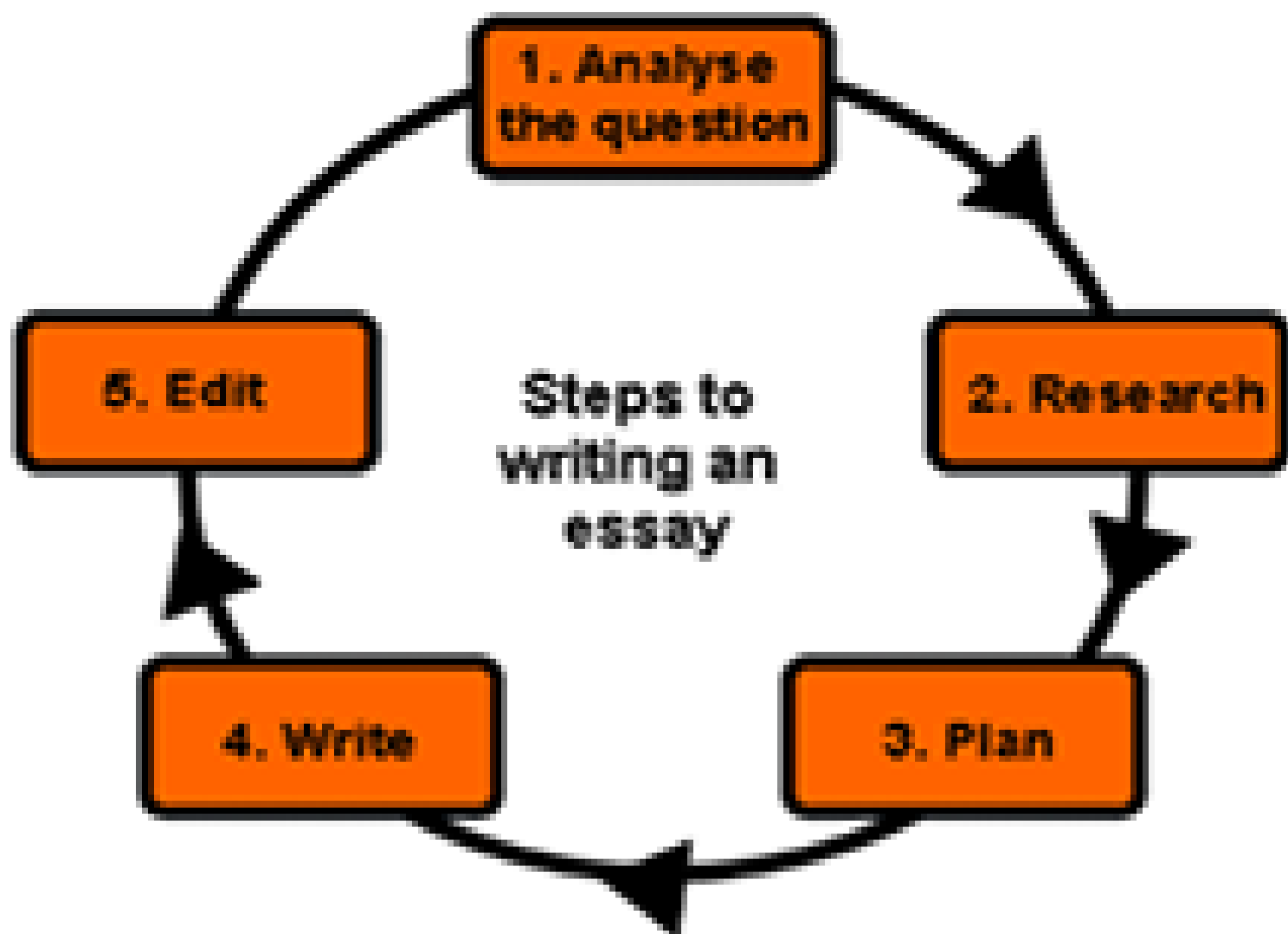
Essay Writing Techniques

Aim: To develop the communicative competence, comprehension and appreciation of the learners in the English Language.

Learning outcomes:

- (i) The learner can demonstrate the ability to communicate information, ideas and opinions in a clear, concise, logical and appropriate manner.
- (ii) The learner can write in standard English.
- (iii) The learner can plan, organize and write paragraphs, using appropriate punctuation.
- (iv) The learner can employ different forms of writing to suit a range of purposes.





Types of Essays

Effectively writing different types of essays has become critical to academic success. Essay writing is a common school assignment, a part of standardized tests, and a requirement on college applications. Often on tests, choosing the correct type of essay to write in response to a writing prompt is key to getting the question right. Clearly, students can't afford to remain confused about types of essays.

There are over a dozen types of essays, so it's easy to get confused. However, rest assured, the number is actually more manageable. Essentially there are four major types of essays.

Four major types of essays.

Distinguishing between types of essays is simply a matter of determining the writer's goal. Does the writer want to tell about a personal experience, describe something, explain an issue, or convince the reader to accept a certain viewpoint? The four major types of essays address these purposes:

1. Narrative essays: Telling a story

In a narrative essay, the writer tells a story about a real-life experience. While telling a story may sound easy to do, the narrative essay challenges students to think and write about themselves. When writing a narrative essay, writers should try to involve the reader by making the story as vivid as possible. The fact that narrative essays are usually written in the first person helps engage the reader. “I” sentences give readers a feeling of being part of the story. A well-crafted narrative essay will also build towards drawing a conclusion or making a personal statement.

2. Descriptive essays: Painting a picture

A cousin of the narrative essay, a descriptive essay paints a picture with words. A writer might describe a person, place, object, or even memory of special significance. However, this type of essay is not description for description's sake. The descriptive essay strives to communicate a deeper meaning through the description.

In a descriptive essay, the writer should show, not tell, through the use of colorful words and sensory details. The best descriptive essays appeal to the reader's emotions, with a result that is highly evocative.

3. Expository essays: Just the facts.

The expository essay is an informative piece of writing that presents a balanced analysis of a topic. In an expository essay, the writer explains or defines a topic, using facts, statistics, and examples. Expository writing encompasses a wide range of essay variations, such as the comparison and contrast essay, the cause and effect essay, and the “how to” or process essay. Because expository essays are based on facts and not personal feelings, writers don’t reveal their emotions or write in the first person.

4. Persuasive essays: Convince Me.

While like an expository essay in its presentation of facts, the goal of the persuasive essay is to convince the reader to accept the writer's point of view or recommendation. The writer must build a case using facts and logic, as well as examples, expert opinion, and sound reasoning. The writer should present all sides of the argument, but must be able to communicate clearly and without equivocation why a certain position is correct.

Starting your essay assignment

Once you've picked your topic - if you've been given a choice - don't start writing straight away.

Do your research. Gather as much information about the subject

Review the resources, and cross off any repetitive ones or those that lack real substance.

Now that you have a shortlist, you'll start to see patterns and argument emerging.

Now, write your outline. This is where you start organizing the pieces of information and the messages in a logical order.

flesh it out.

In general, that outline is going to start with an introduction or summary, introduce a topic (or topics), back up the position in those topics, then end with a conclusion.

Now that you've got the flow, put in the references and/or content to sit under each main heading.

This leaves you with the 'skeleton' of your essay; now it's time to flesh it out.

A thesis statement is the single, specific claim that your essay supports. A strong thesis **answers the question you want to raise**; it does so by presenting a topic, your precise opinion on the topic, and a reasoning blueprint that sketches out the organization for the rest of the paper. A good thesis is not merely a factual statement, an observation, a personal opinion or preference, or the question you plan to answer.

Academic writing style

Academic essays should be written in a formal style. Avoid:

clichés ("the flaws in this argument stand out like a sore thumb")

contractions ("don't", "aren't", "it's")

phrases that sound like speech ("well, this bit is really fascinating")

subjective descriptions ("this beautiful sculpture")

Use the first person "I" only where appropriate (e.g. when writing up your own experience or professional case study). Where possible use the third person, for example "It can be argued" instead of "I think"

Use plain language - you don't have to search for a more "academic-sounding" word when a simple one will do. accurate expression of ideas, not jargon or confusing language. Shorter sentences are usually clearer than long complex ones, but make sure it is a whole sentence and not just a clause or phrase.

Integrating evidence and your own ideas

Your argument is your reasoned answer to the essay question, supported by evidence. The books, articles, and research material that you read for your essay provide this evidence to back up your points. The way in which you select and interpret the evidence, and explain why it answers the question, is where you demonstrate your own thinking.

For each point that you make in your essay, you need to support it with evidence. There are many different kinds of evidence, and the type you use will depend on what is suitable for your subject and what the essay question is asking you to do.

For example, you might back up a point using a theory (one kind of evidence) then show how this theory applies to a specific example in real life (another kind of evidence).

For example, you might back up a point using a theory (one kind of evidence) then show how this theory applies to a specific example in real life (another kind of evidence).

4. As you get more experienced with essay writing, you will want to adapt this model to suit the structure and shape of your ideas.

Critical analysis

Critical analysis is a key skill for writing essays at university; it allows you to assess the various ideas and information that you read, and decide whether you want to use them to support your points.

It is not a mysterious skill that is only available to advanced students; it is something we do everyday when assessing the information around us and making reasoned decisions, for example whether to believe the claims made in TV adverts. Nor does it always mean disagreeing with something you also need to be able to explain why you agree with arguments.

Critical analysis involves:

Carefully considering an idea and weighing up the evidence supporting it to see if it is convincing.

Then being able to explain **why** you find the evidence convincing or unconvincing.

It helps if you ask yourself a series of questions about the material you are reading. Try using these questions to help you think critically:

- Who is the author and what is their viewpoint or bias?
- Who is the audience and how does that influence the way information is presented?
- What is the main message of the text?
- What evidence has been used to support this main message?
- Is the evidence convincing; are there any counter-arguments?
- Do I agree with the text and why do I agree or disagree?

Some ways to get more critical analysis into your essays

Avoid unnecessary description – only include general background details and history when they add to your argument, e.g. to show a crucial cause and effect. Practice distinguishing between description (telling what happened) and analysis (judging why something happened).

Interpret your evidence – explain how and why your evidence supports your point. Interpretation is an important part of critical analysis, and you should not just rely on the evidence "speaking for itself".

Be specific - avoid making sweeping generalizations or points that are difficult to support with specific evidence. It is better to be more measured and tie your argument to precise examples or case studies.

Use counter-arguments to your advantage – if you find viewpoints that go against your own argument, don't ignore them. It strengthens an argument to include an opposing viewpoint and explain why it is not as convincing as your own line of reasoning

Editing and proofreading

You might have had enough of your work by now, and be hoping to just hand it in! However, it's worth taking some time to check it over. **Markers often comment that more time spent on editing and proofreading could have really made a difference to the final mark.**

Editing

Editing involves checking whether all your points are in the right order and that they are all relevant to the question.

Be ruthless at this stage – if the information isn't directly answering the question, cut it out! You will get many more marks for showing you can answer the question than you will for an unordered list of everything you know about a topic.

Put yourself in the reader's position – can they follow the points you are making clearly? You know what you are trying to say, but will your reader? Are there gaps in your reasoning to be explained or filled

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Proofreading

Identifying your own mistakes and correcting them is an important part of academic writing: this is what you do when you proofread.

Ideally leave a day between finishing your essay and proofreading it. You won't be so close to your work, so you will see your errors more easily. Try reading your essay aloud, as this will slow you down, make you focus on each word, and show you when your sentences are too long.

It can help to have a friend read through your work but developing your own proofreading skills is better. Your friend won't always be available!

Writing your essay

Write a draft first - it may take a couple of goes to get the final essay right.

Start with a sentence or paragraph that will intrigue the reader and make them want to read on. If you start with straight statements of facts, the reader could soon lose concentration.

Follow your outline and stick to it, otherwise your reasoning and argument may meander off and lose direction.

End with a strong conclusion that summarizes the argument or position, and repeat major pieces of evidence.

Now, go back and rewrite it. Then rewrite it again if you have to until you either run out of time, or feel you've got it right.

Now review it, and get someone else to read it to see if you've missed anything.

Some general writing tips

- Use short sentences: try turning commas into full stops, to break a long sentence into two
- Don't use unnecessarily long words to prove how clever you are; let your knowledge demonstrate that
- Use plain language that anyone could understand
- Writing is about getting it down on paper, reviewing and then editing; don't expect it to be perfect first time

- Read your essay out loud: are you stumbling at any point? If so, review and edit.
- Keep your paragraphs short, to make the words on the page less daunting.
- Any spelling errors will make the reader stumble, and leave them with a bad impression

I thank
you!



CA
in LHO TAB

2 } Compare & Contrast.
3 } Clam fig
4 } Cause & Effect - 3

1 { Descriptive,
2 { Illustrative
4 { Debatable
4 { Unsettled

7

2: Speech 4: Subjective
descriptions

"don't"

2. Speech "Well, Mr. Galt is
leaving tonight."

It can be third person
It can be argued that

Do
not
used -

YEAR 1

B32

Integrating evidence and your own ideas

0505
2014

Originality -

answers ideas; decide how, to support point-
transmit down -

Critical analysis involves:

Carefully considering an idea and weighing

up the evidence supporting it to see if it is
convincing. Then being able to explain why you
find the evidence convincing and unconvincing.

It helps if you ask yourself a series of
questions about the material you are reading.
Try using these questions to help you think
who is the author? What is his viewpoint or bias?
Who is the audience and how does that influence
the way information is presented?

What is the main message of the text?

Be specific, use counterargument,

B354-1

x has / Research done by x shows that y =

0505

2014

1400

Write the first draft, an introduction, body and a conclusion. To make it as interesting as you can, to interest the reader.

Some general writing tips

> Use short sentences; try turning commas into full stops, to break a long sentence into two.

> Don't use unnecessarily long words to prove how clever you are; let your knowledge demonstrate that

> Use plain language that anyone could understand

> Writing is about getting it down on paper, reviewing and then editing; don't expect it to be perfect first time.

> A paragraph has an introduction, beginning and a

1413

Conclusion or key sentence. For example:

PARAGRAPH writing

A: A paragraph - A good composition consists of well-constructed paragraphs. Therefore, it will be useful to know the salient characteristics of paragraphs. Each paragraph in a composition deals with a particular aspect of the subject or topic. The series of sentences in a paragraph are related.

NURS ^{WJ} B The main elements of a paragraph are the
follows

CHOTANB

- 1425
- > Topic sentence (often at the begin
 - > Develops
 - > Terminator

The topic sentence may be placed anywhere in the paragraph though it often comes at the begin. A terminator may not be necessary; the writer should be able to know it an conclusion -

The sentences have an order, a logical sequence, and they develop a central idea and this idea is contained in the topic sentence. This topic sentence starts at the begin of the paragraph and is called an introducer.

These sentences have an order, a logical sequence, and they develop a central idea and this idea is contained in the topic sentence. This topic sentence, if it is at the

- ④ beginning of the paragraph may be an introducer. The series of related sentences may be called develops. A terminator brings the paragraph to a satisfying close. =
- 143)

Schuster

④

VERA

Nurs / wt

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Cohesiveness - flow of ideas -

Writing - # REFERENCE - to subject matter -

English

OPTIONAL =

600

1: What advantages and disadvantages for society arise through people living together?

2: How far do you agree that university degrees are a waste of time and effort?

3: To what extent does gambling cause problems to individuals and to society?

4: 'Criminals are born, not made' To what extent do you agree with this view?

5: Explain what constitutes a balanced diet and why is it important?

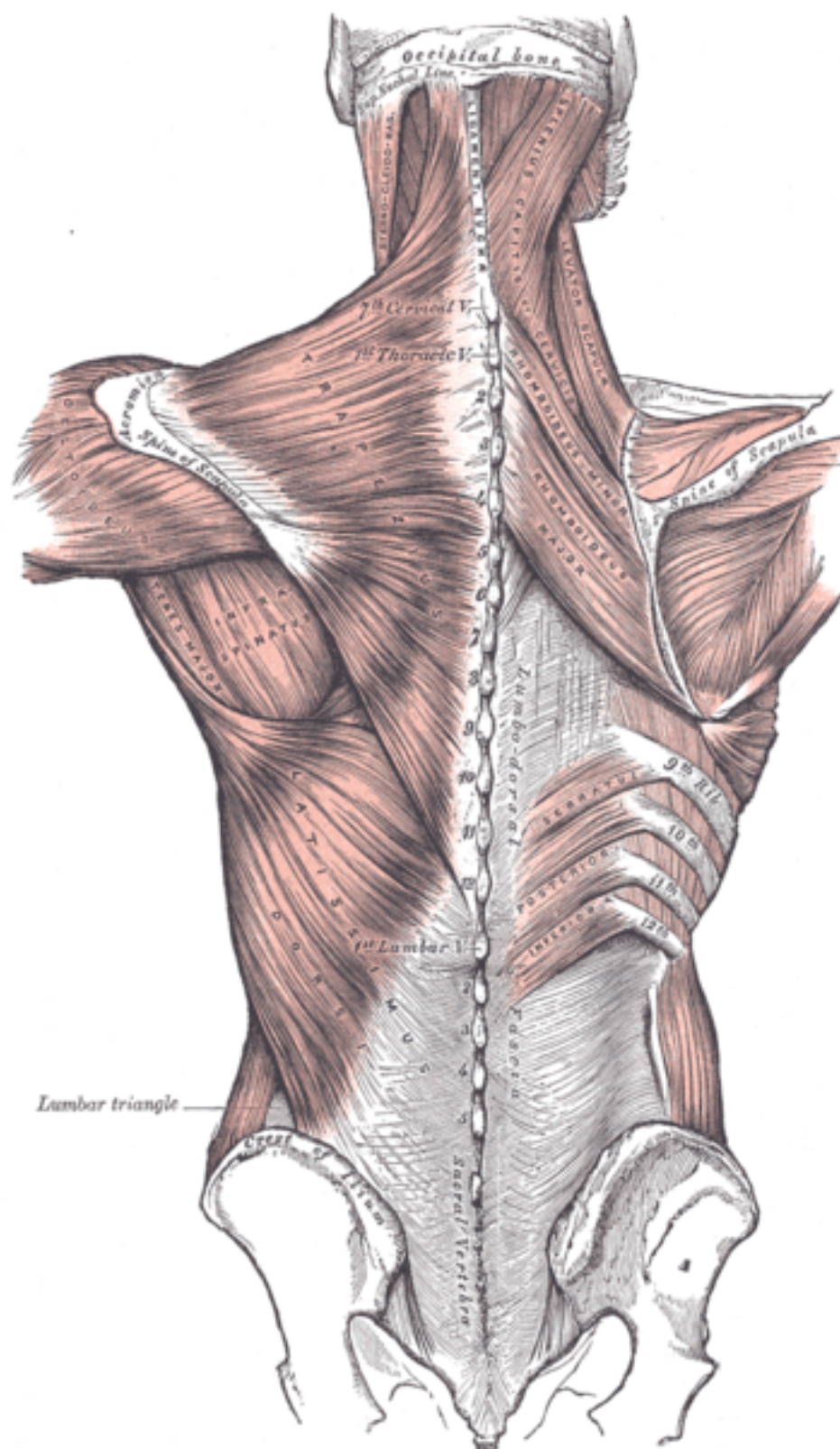
Life Skills - develop

enhance

Standard, make a presentation.

a part of writing ⑥

Need further, bibliography -



CELL ORGANELLES, STRUCTURES + FUNCTIONS

CELL MEMBRANE

location: on the outside of an animal cell and inside the cell wall of a plant cell

function: boundary that provides limited support to the cell and controls movement of materials in and out of the cell

CELL WALL

location: on the outside of a PLANT CELL

function: gives support and shape to cell

CHLOROPLASTS

location: distributed throughout the cytoplasm of a PLANT CELL

function: makes food by photosynthesis

CYTOPLASM

location: jellylike material throughout a cell

function: cellular liquid in which organelles are suspended

ENDOPLASMIC RETICULUM (ER)

location: distributed throughout the cytoplasm of a cell

function: makes lipids (fats) and packages proteins for delivery out of the cell

GOLGI COMPLEX (body/apparatus)

location: distributed throughout cytoplasm of a cell

function: changes, packages, and transports materials out of the cell

LYSOSOMES

location: distributed throughout cytoplasm of an ANIMAL CELL

function: digests food particles, waste, and foreign invaders (viruses, bacteria ...)

MITOCHONDRIA

location: distributed throughout cytoplasm of a cell

function: breaks down food molecules and releases energy

NUCLEUS

location: near the center of a cell

function: controls cell activities

RIBOSOMES

location: on ER and throughout the cytoplasm of a cell

function: make proteins

VACUOLE

location: distributed throughout the cytoplasm of a PLANT CELL

function: stores water and other substances